

Assembly Bill No. 442

CHAPTER 1161

An act to amend Section 4426 of, and to repeal Section 4427 of, the Business and Professions Code, to amend Section 49557.2 of the Education Code, to amend Sections 1356, 1797.199, 53300, 100171, 120955, 124030, 124040, 124120, and 124250 of, to add Sections 26157, 104188, 124033, 124977, 125190, and 127280.1 to, and to add Article 6 (commencing with Section 101315) to Chapter 3 of Part 3 of Division 101 of, the Health and Safety Code, to amend Sections 12693.17, 12693.43, 12693.45, 12693.70, and 12693.981 of, and to amend, repeal, and add Section 12693.41 of, the Insurance Code, and to amend Sections 4094.2, 4380, 4418.3, 4418.7, 4640.6, 4643, 4646.5, 5600.8, 5869, 5881, 5882, 5883, 14005.41, 14011.6, 14019.3, 14051, 14085.7, 14085.8, 14103.6, 14105.2, 14105.3, 14105.31, 14105.33, 14105.337, 14105.34, 14105.35, 14105.37, 14105.38, 14105.39, 14105.405, 14105.42, 14105.43, 14105.45, 14125, 14132, 14132.26, 14132.88, 14132.95, 14163, 14495.10, 16809, 16809.4, and 18925 of, to add Sections 4418.2, 4418.25, 4781.5, 5767, 14000.03, 14000.5, 14011.7, 14011.8, 14011.9, 14105.18, 14105.332, 14105.46, 14105.47, 14105.8, 14105.85, 14132.73, and 14150 to, to add and repeal Sections 4631.5 and 14105.436 of, to repeal Sections 4847, 14105.65, 14105.91, 14105.915, and 14105.916 of, and to repeal and amend Sections 14105.4 and 14105.41 of, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 2002. Filed
with Secretary of State September 30, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 442, Committee on Budget. Health: budget trailer.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

Existing law requires, as a condition of a pharmacy's participation in the Medi-Cal program, the pharmacy to charge a price that does not exceed the Medi-Cal reimbursement rate for prescription medicines and an amount to cover electronic transmission charges by Medicare beneficiaries. Existing law requires the department to monitor pharmacy participation under these provisions, conduct a study of the adequacy of the Medi-Cal pharmacy reimbursement rates, and report the results of



the study to the Legislature by July 1, 2002. Under existing law, these provisions are repealed as of January 1, 2003.

This bill would delete the repeal of these provisions, thereby extending the operation of these provisions indefinitely. The bill would delete the requirement of the department to report the results of the study by July 1, 2002.

Existing law provides for a school lunch program under which eligible pupils receive free or reduced price meals. Existing law, effective July 1, 2002, authorizes the incorporation into the school lunch program application packet, or notification of eligibility, various notifications to parents and guardians, including those with regard to the confidentiality of school lunch application information and its use for purposes of the Medi-Cal program.

This bill would change the effective date of the above notification provisions from July 1, 2002, to July 1, 2003. It would also revise the notifications that may be incorporated under this provision regarding the confidentiality of the school lunch application information and its use for purposes of the Medi-Cal program and would make related and technical changes.

Existing law provides for the regulation and licensure of health care service plans, administered by the Department of Managed Health Care. Existing law requires a health care service plan to reimburse the director for the actual cost of processing an application for licensure as a health care service plan and for a health care service plan's share of all costs and expenses reasonably incurred in the administration of these regulatory provisions. In addition, existing law authorizes the director, by notice on or before September 15, 2000, to require a health care service plan to pay an additional assessment to provide the department with sufficient revenues to support various costs and expenses for the 2000–01, 2001–02, and 2002–03 fiscal years.

This bill would require that notice for the additional assessment be provided each year, rather than on or before September 15, 2000. The bill would expressly require, if a health care plan fails to pay the additional assessment for the 2001–02 fiscal year, the assessment of the amount due for the 2001–02 fiscal year in the 2002–03 fiscal year, in addition to the amount due in the 2002–03 fiscal year.

Existing law establishes the Trauma Care Fund, effective August 10, 2001, which is continuously appropriated to the Emergency Medical Services Authority for purposes of allocating funds to local emergency medical services (EMS) agencies for certain trauma centers. Existing law requires the authority, within 30 days of the effective date of the establishment of the fund and related provisions, to request all local



EMS agencies with an approved trauma plan to submit specified information.

This bill, instead, would require the authority to request all local EMS agencies to submit this information within 30 days of the effective date of the enactment of an appropriation for purposes of implementing provisions relating to the Trauma Care Fund.

Existing law establishes the Toxic Mold Protection Act of 2002, which requires the State Department of Health Services to take specified steps related to reducing toxic mold exposure. The act declares that it shall be implemented only to the extent that the department determines that funds are available for its purposes.

This bill would authorize the department to receive voluntary contributions to support the department's activities pursuant to the act. It would establish the Public Health Protection from Indoor Mold Hazards Fund, a continuously appropriated fund, into which those contributions would be deposited for use by the department in implementing the act, thereby making an appropriation.

The existing California Statewide Supportive Housing Initiative Act requires the State Department of Mental Health to award grants to local government or private nonprofit agencies for services to a target population. The act requires the department to make all grant awards from funds allocated in the Budget Act of 2000 for the supportive housing initiative no later than June 30, 2002, and to expend the funds allocated for those grants no later than June 30, 2004.

This bill would revise this provision to require, instead, the department to make all grant awards from funds allocated in the Budget Act of 2001 for the supportive housing initiative no later than June 30, 2002, and to expend the funds allocated for those grants no later than June 30, 2005.

Existing law vests the State Department of Health Services with various powers, functions, and duties with respect to the administration and oversight of various health programs and facilities. Existing law requires that any adjudicative hearing that the department is authorized or required to conduct be conducted pursuant to the Administrative Procedure Act. The staff assigned to the hearing office of the State Department of Health Services is authorized to determine the time and place of an administrative adjudication hearing conducted pursuant to these procedures.

This bill would require that formal hearings requested by institutional Medi-Cal providers and health facilities be held in Sacramento and would authorize informal conferences concerning appeals by those entities to be held in Sacramento or Los Angeles.



Existing law provides for the allocation of state aid to the administrative bodies of qualifying local health departments according to a specified formula.

This bill would establish procedures and requirements to govern the allocation to, and expenditure by, local health jurisdictions of federal funding received for the prevention of, and response to, bioterrorist attacks and other public health emergencies.

The bill would provide that federal funding received by the State Department of Health Services for bioterrorism preparedness and emergency response is subject to appropriation in the annual Budget Act.

Existing law requires the State Department of Health Services to establish and administer the Cancer Research Program and authorizes the department to award grants under the program.

This bill would establish a maximum indirect cost rate that may be charged on any cancer research program grant awarded to any institution under these provisions.

Existing law requires the Director of Health Services to develop a list of drugs to be provided under a program for the treatment of persons infected with the human immunodeficiency virus (HIV) and requires manufacturers of drugs on the list to pay the department a rebate that is equal to the rebate that would apply to the drug under certain provisions of federal law.

This bill would require these manufacturers to pay an additional rebate to be negotiated by each manufacturer with the department.

Under existing law, the governing body of each county is required to establish a community child health and disability prevention program for the purpose of providing early and periodic assessments of the health status of children in the county.

This bill would require, commencing July 1, 2003, that all applications for services under the child health and disability prevention program be filed electronically as provided under the bill. The bill would define “child health and disability prevention provider” for purposes of the provisions concerning child health and disability prevention programs, and would make related changes.

Existing law requires the State Department of Health Services to conduct a community outreach and awareness campaign relative to a specified newborn hearing screening program and the value of early hearing testing.

This bill, instead, would authorize the department to conduct this outreach and awareness campaign.

Existing law requires the Maternal and Child Health Branch of the department to administer a comprehensive shelter-based services grant



program to battered women's shelters. In implementing the program, the department is required to consult with a designated advisory council that shall remain in existence until January 1, 2003.

This bill would provide that the advisory council shall remain in existence until January 1, 2006.

Existing law requires the department to charge a fee to all payers for any tests or activities performed pursuant to provisions relating to genetic disorder prevention services, including the Hereditary Disorders Act. Existing law requires that any fee charged for screening and followup services provided to Medi-Cal eligible persons, health care service plan enrollees, or persons covered by disability insurance policies be paid directly to the Genetic Disease Testing Fund, a continuously appropriated fund, to be used for purposes of the Hereditary Disorders Act.

This bill, commencing July 1, 2002, would recast these provisions to require, instead, the department to charge a fee to the hospital of birth or to families of a newborn, for births not occurring in a hospital, for newborn screening and followup services. The bill would require that payments pursuant to this provision be made to the Genetic Disease Testing Fund. The bill would prohibit the department from charging or billing Medi-Cal beneficiaries for services provided under these provisions relating to genetic disorder prevention services.

Existing law requires the State Department of Health Services to establish and administer a program for the medical care of persons with genetically handicapping conditions.

This bill would provide that the department is considered to be the purchaser, but not the dispenser or distributor, of blood factor products, under the Genetically Handicapped Person's Program.

Existing law requires that all health facilities, except those owned and operated by the state, be charged each year a designated fee established, in accordance with certain requirements, by the Office of Statewide Health Planning and Development to pay for certain functions required to be performed by the office.

This bill would authorize the State Department of Health Services to expend \$200,000 of the fees collected pursuant to this provision for use in the 2002–03 fiscal year for data collection on, analysis of, and reporting on, maternal and perinatal outcomes, if funds are appropriated in the Budget Act of 2002 for that purpose.

Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health services to eligible children, and defines "family contribution sponsor" for purposes of these provisions.

This bill would revise the definition of family contribution sponsor.



Existing law provides for reimbursement to providers participating in the Healthy Families Program for certain services provided up to 90 days prior to the effective date of coverage under the program.

This bill would repeal these reimbursement provisions and would require instead, effective April 1, 2003, the board, in consultation with the State Department of Health Services, to implement a preenrollment program into the Healthy Families Program or the Medi-Cal program. The bill would authorize the board to adopt emergency regulations to implement this preenrollment program. The bill would make various other changes in program requirements related to family contributions, disenrollment, and eligibility to participate in the program.

Existing law establishes the Healthy Families-to-Medi-Cal Bridge Benefits Program to provide any person enrolled for coverage under the Healthy Families Program who meets certain criteria with a two calendar-month period of health care benefits in order to provide the person with the opportunity to apply for Medi-Cal. Existing law authorizes the implementation of this program only if a specified State Children's Health Insurance Program waiver is approved, and at the time the waiver is implemented.

This bill would delete this waiver restriction on implementation of the Healthy Families-to-Medi-Cal Bridge Benefits Program.

Existing law requires the State Department of Social Services to establish a foster care rate for each community treatment facility program, and requires for the 2001–02 fiscal year that a community treatment facility program be paid a community treatment facility supplemental rate. Subject to the availability of funds, this payment is required to be shared by the state and the counties.

This bill would extend to the 2002–03 fiscal year the requirement that the supplemental rate be paid.

Existing law requires the Director of Mental Health to award matching grants to local educational agencies to pay the state share of the costs of providing programs that provide school-based early mental health intervention and prevention services to eligible pupils at schoolsites of eligible pupils, based on certain priorities and specifications.

This bill would revise these priorities and specifications.

Existing law states the intent of the Legislature relating to the transition process of persons with developmental disabilities from a developmental center to a community living arrangement through the development of an individual program plan process.

This bill would require the State Department of Developmental Services to establish policies and procedures for the development by regional centers of an annual community placement plan, would require the department to review the plans, and would authorize the department



to make allocations to regional centers to develop the plans. It would also require, until July 1, 2004, a regional center to take specified actions upon the department's determination of the amount of unallocated reduction in the regional center's purchase of service budget.

The bill also would specify additional requirements for the State Department of Developmental Services, developmental centers, and regional resource development projects pertaining to the coordination of efforts among those entities, the provision of services to consumers, and the collection and availability of data.

Existing law provides for the provision of services to persons with developmental disabilities by regional centers, pursuant to contracts with the State Department of Developmental Services. Existing law imposes various requirements on the department and the regional centers with respect to these contracts.

The bill would provide that any contract between the department and a regional center entered into on and after January 1, 2003, shall require that all employment contracts entered into with regional center staff or contractors be available to the public for review, except with respect to the social security number of the contracting party. It would also prohibit any employment contract, or portion thereof, from being deemed confidential or unavailable for public review.

Existing law requires that a regional center perform initial intake, including deciding whether to provide assessment, within 15 days following a request for assistance. Existing law requires that if assessment is needed, the assessment shall be performed within 60 days following the initial intake.

This bill, instead, would require, before July 1, 2003, that the assessment be performed within 120 days following initial intake, and on or after July 1, 2003, that the time limit for performing the assessment be within 60 days following initial intake.

Existing law requires the development of an individual program plan for an individual with developmental disabilities eligible for regional center services. Existing law requires the State Department of Developmental Services to annually review a random sample of individual program plans at each regional center.

This bill, instead, would require a biennial review by the department pursuant to this provision.

The bill, with certain exceptions, would prohibit, for the 2002–03 fiscal year only, a regional center from expending any purchase of service funds for the startup of any new program unless certain conditions exist.

Existing law requires the State Department of Developmental Services to coordinate, or require each regional center to coordinate, a



meeting within each regional center catchment area between the regional center, the local health facility providers, the State Department of Health Services representatives from the local district office, and the State Department of Developmental Services center staff for purposes of better coordinating services and supports provided to regional center consumers in licensed health facilities.

This bill would repeal this requirement.

Existing law authorizes the State Department of Developmental Services to allocate funds appropriated in a specified item of the Budget Act of 2000 to county mental health programs that meet programmatic goals and model adult system of care programs to the satisfaction of the department or for Children's System of Care programming.

This bill, instead, would authorize the department to allocate funds appropriated in a specified item of the annual Budget Act for these purposes.

Under the Children's Mental Health Services Act, the State Department of Mental Health is authorized to enter into annual performance contracts with participating counties, known as system of care counties, for the delivery of mental health services to seriously emotionally disturbed children. Existing law requires the department to provide participating counties with a contract with an independent evaluator to measure performance outcomes and provide technical assistance to the state and counties and provide training, consultation, and technical assistance for county applicants and participants.

This bill would eliminate the requirement that the department provide the above-described independent evaluator and the training, consultation, and technical assistance, and would require instead that the department provide technical assistance related to system evaluation. The bill would make related changes.

Existing federal law requires that California's state plan for medical assistance under the medicaid program, known as the Medi-Cal program, provide for entering into cooperative arrangements with the state agencies responsible for the administration of health services and vocational rehabilitation services in the state looking toward maximum utilization of these services in the provision of medical assistance under the plan.

This bill would provide, notwithstanding any other provision of law, upon additional funds being appropriated and budgeted for the support of the services identified within the scope of work of an agreement of the type specified under federal law and previously entered into by the State Department of Health Services, the amount of the encumbrance in such an agreement shall be amended, by operation of law, to reflect the newly appropriated and budgeted funds. It would also provide that once an



agreement is entered into by the department, the agreement shall continue in effect indefinitely and need not be amended unless the department changes the scope of work to be provided under the agreement.

Under existing law, the Medi-Cal program is administered by the State Department of Health Services.

This bill would authorize the Director of Health Services, on a regional pilot project basis, to enter into contracts with one or more nonprofit organizations to perform the functions of the department's Office of the Ombudsman, with services provided by the ombudsman to be made available to any person who may be eligible for, or who is receiving, benefits under the Medi-Cal program.

Existing law provides that any child who is less than 6 years of age and who has been determined to be eligible for free meals under the National School Lunch Program has met the income eligibility requirements for participation in the Medi-Cal program, without a share of cost.

This bill would revise this provision to replace the reference to income eligibility requirements with income documentation requirements and would make conforming changes.

Existing law, effective July 1, 2002, requires each county to participate in a statewide pilot project to grant Medi-Cal program eligibility to, and enroll in the Medi-Cal program, any child under 6 years of age enrolled in school and eligible for free meals under the National School Lunch Program.

This bill would change the effective date of this and related provisions from July 1, 2002, to July 1, 2003. It would also revise this provision to require each county, instead, to determine Medi-Cal program eligibility for any child described above, and would authorize the department to exercise a specified federal option for eligibility determinations.

Existing law requires the State Department of Health Services to exercise certain options provided under federal law to implement a program for accelerated enrollment of children in the Medi-Cal program.

This bill would require a county, upon receipt of an application for a child who has accelerated enrollment coverage under this program, to determine whether the child is eligible for Medi-Cal benefits and to report this finding to the medical eligibility data system. The bill would provide that this provision shall become operative on July 1, 2002, or the date that the program of accelerated enrollment coverage for children takes effect, whichever is later.

This bill would require the State Department of Health Services and the Managed Risk Medical Insurance Board to exercise certain options provided under federal law to implement a program for preenrollment of children into the Medi-Cal program and the Healthy Families



Program. The bill would require the department to develop an electronic application before July 1, 2003, to serve as the application for preenrollment into the Medi-Cal program or the Healthy Families Program and to also serve as an application for the Child Health and Disability Prevention program. The bill would specify requirements for the processing of the electronic application.

The bill would provide for the termination within a designated time of benefits provided to an individual pursuant to a preliminary determination under Medi-Cal as described under federal law, unless an application for medical assistance under the state plan is filed.

The bill would require the State Department of Health Services, on or before October 1, 2002, to issue instructions to all counties to establish an automated system for tracking the status of applications received by county welfare departments from the centralized processing entity, which screens applications for eligibility benefits under the Medi-Cal program and forwards the applications to the appropriate county.

Existing law provides that a beneficiary or any person on behalf of the beneficiary who has paid for health care services otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a return from the provider of any part of the payment that meets specified requirements. Existing law also provides for the Medi-Cal reimbursement of a provider upon submission of proof of eligibility.

This bill would require the State Department of Health Services, to the extent permitted by federal law, to waive overpayments made to a pharmacy provider that would otherwise be reimbursable to the department for prescription drugs returned to the pharmacy provider from a nursing facility upon discontinuation of the drug therapy or death of the beneficiary.

Under existing law, for purposes of the Medi-Cal program, “medically needy person” is defined to include, among other described persons, until October 1, 2002, a child who is eligible to receive Medi-Cal benefits under an interstate agreement for adoption assistance and related services and benefits to the extent federal financial participation is available.

This bill would delete reference to October 1, 2002, and thereby include the above-described child within the definition of a medically needy person indefinitely.

Existing law requires the county in which a person resides to determine a person’s eligibility for Medi-Cal benefits and continued eligibility.

To the extent this bill would increase the counties’ responsibilities for eligibility determination, it would impose a state-mandated local program.



Existing law creates the Medi-Cal Medical Education Supplemental Payment Fund, and the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund, in the State Treasury as continuously appropriated funds, which consist of various moneys for use by public agencies for health care programs or purposes. Under existing law, these provisions become inoperative on July 1, 2002, and as of January 1, 2003, are repealed.

This bill would extend the inoperative dates to July 1, 2004, and the repeal dates to January 1, 2005. By extending the operation of continuously appropriated funds, this bill would result in an appropriation.

Existing law authorizes the State Department of Health Services to require that a provider receive prior authorization before providing Medi-Cal services when it is determined that the provider has been rendering unnecessary services.

This bill would authorize the department to contract for staff to accomplish treatment authorization request reviews and to carry out contracting activity with manufacturers of single-source drugs.

Existing law requires the State Department of Health Services to administer various health programs, including the California Children's Services Program, Genetically Handicapped Person's Program, Breast and Cervical Cancer Early Detection Program, State-Only Family Planning Program, and Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

This bill would require that provider rates of payment for services rendered in all of these programs be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program, would authorize the director to identify, by regulation, other programs that would be subject to this requirement, and would authorize reimbursement at rates greater than the Medi-Cal rate if provided by regulation of the director.

Existing law under the Medi-Cal program prohibits the allowable markup payable for the dispensing of medical supplies by assistive device and sickroom supply dealers and pharmacies from exceeding 25% of the cost of the item dispensed, as defined by the department.

This bill would prohibit the allowable markup payable for these supplies from exceeding 23% of the cost of the item dispensed. It would also prohibit payment for diabetic testing supplies from exceeding the cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.

Existing law provides that certain contracts entered into by the department on a bid or negotiated basis for drugs, product-type health



services, and clinical laboratory services under the Medi-Cal program have no force and effect unless approved by the Department of Finance. Existing law exempts these contracts from certain requirements under the Public Contract Code, including a requirement of approval by the Department of General Services.

This bill would delete the requirement that these contracts be approved by the Department of Finance, would provide for additional exemptions from various requirements under the Public Contract Code and the Government Code, and would make related changes.

Existing law authorizes the State Department of Health Services to contract with less than all manufacturers or clinical laboratories including only one manufacturer or clinical laboratory, on a bid or nonbid basis.

This bill would delete this authorization and would require the department to take specified actions for purposes of implementing certain contracting provisions.

Existing law authorizes the State Department of Health Services to enter into contracts with manufacturers of single-source and multiple-source drugs on a bid or nonbid basis pursuant to specified procedures and to maintain a list of contract drugs. Under existing law, these provisions are repealed as of January 1, 2003, and replaced with alternative provisions implementing the Medi-Cal drug formulary program.

This bill would delete the repeal of these provisions, thereby extending the authority of the department to enter into the above-described contracts indefinitely. The bill would repeal the alternative provisions related to the implementation of the Medi-Cal drug formulary program.

Existing law provides for various increases to the reimbursement to pharmacists for all drug prescription claims reimbursed through the Medi-Cal program.

This bill, until July 1, 2004, would require the department to reduce reimbursement to pharmacists in the amount reimbursement was increased pursuant to these provisions with respect to pharmacy services rendered on and after the date that this bill is enacted, and would exempt claims submitted by pharmacists for beneficiaries in a nursing facility.

Existing law provides that if certain conditions are met, a new drug designated as having an important therapeutic gain and approved for marketing by the federal Food and Drug Administration shall be immediately included on the list of contract drugs for 3 years.

This bill would delete this provision.

Existing law permits any drug suspended from the list of contract drugs for at least 12 months to be deleted from the list of contract drugs.



This bill would remove the 12-month time period as a condition prior to deletion of a drug from the list of contract drugs. It would also establish a list of preferred prior authorization drugs as a subset of the list of contract drugs and would permit a manufacturer of a drug deleted from, or not added to, the list of contract drugs to request inclusion on that list.

Existing law specifies conditions under which certain drugs for use in the treatment of acquired immune deficiency syndrome (AIDS) or an AIDS-related condition or cancer are deemed approved for addition to the Medi-Cal list of contract drugs or considered a Medi-Cal benefit.

This bill would require, commencing July 1, 2002, all pharmaceutical manufacturers to provide to the State Department of Health Services a state rebate in addition to rebates pursuant to other provisions of state or federal laws for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to the above described provisions related to drugs used to treat AIDS and cancer. This provision would become inoperative on July 1, 2005, and would be repealed on January 1, 2006.

Existing law requires the State Department of Health Services to establish a list of Maximum Allowable Ingredient Costs (MAIC) for drugs based on reference to certain drug brands.

This bill would revise the basis for establishing the list of MAIC for drugs. The bill would require the department to update MAICs at least every 2 months and to establish the estimated acquisition cost, as defined, of legend and nonlegend drugs, as defined. The bill would also require the department to establish a list of medical supplies, including utilization controls applied to each medical supply product, and a list of Maximum Allowable Product Costs (MAPC) for medical supplies. The bill would require the department to repeal certain regulations related to medical supplies.

This bill would authorize the State Department of Health Services to enter into contracts with manufacturers of enteral formulae that can be used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. The bill would require the department to maintain a list of those products for which contracts have been executed.

Existing law provides for the establishment of provider reimbursement rates for incontinence medical supplies covered by the Medi-Cal program.

This bill would revise the method for determining the reimbursement rate.

Under the Medi-Cal program, specified medical benefits are provided to public assistance recipients and certain other low-income persons.



This bill would include the purchase of prescribed enteral formulae and diabetic testing supplies as a covered benefit subject to utilization controls. It would also revise the covered benefits related to dental care.

Existing law requires the State Department of Health Services to develop a federal waiver program to test the efficacy of providing an assisted living benefit to beneficiaries under the Medi-Cal program. Existing law prohibits the department from implementing the waiver program developed under this provision if the program will result in additional costs to the state.

This bill, instead, would prohibit the department from implementing the waiver program if the benefits provided pursuant to the program will result in additional costs to the Medi-Cal program.

Under existing law, certain telemedicine services are reimbursable under the Medi-Cal program.

This bill would require the State Department of Health Services to allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telemedicine until June 30, 2004, or until a method for reimbursement is developed, as provided.

Existing law specifies procedures under which personal care services meeting certain conditions, when provided to a categorically needy person, as defined, are a covered Medi-Cal benefit to the extent federal financial participation is available. Under existing law, these provisions become inoperative on July 1, 2002, and as of January 1, 2003, are repealed.

This bill would delete the inoperative and repeal dates, thereby extending these Medi-Cal benefit coverage provisions indefinitely.

Existing law specifies procedures for the monthly advancement of state funds to counties for costs of administration of the Medi-Cal program.

This bill would require, within 60 calendar days of the date that the annual Budget Act is chaptered, the State Department of Health Services to notify the chairpersons of the fiscal committees of each house of the Legislature, the Chairperson and the Vice Chairperson of the Joint Legislative Budget Committee, and appropriate county representatives if the department plans to withhold and not allocate any of the baseline allocation for county Medi-Cal eligibility activities that are appropriated for Medi-Cal administration.

Under existing law, the Medi-Cal program provides for a special methodology of reimbursement of disproportionate share hospitals for the provision of inpatient hospital services. Existing law establishes the Medi-Cal Inpatient Payment Adjustment Fund in the State Treasury, as a continuously appropriated fund, to be used as the source for the nonfederal share of payments to disproportionate share hospitals.



Existing law transfers \$29,757,690 from the fund to the Health Care Deposit Fund for the 2000–01 fiscal year and each fiscal year thereafter.

This bill would transfer \$85,000,000 to the Health Care Deposit Fund for the 2002–03 fiscal year and each fiscal year thereafter. Because the Health Care Deposit Fund is continuously appropriated, this bill would make an appropriation.

Existing law requires the State Department of Health Services to establish a pilot program to provide continuous skilled nursing care as a benefit of the Medi-Cal program when those services are provided in accordance with an approved federal waiver meeting certain requirements. Existing law repeals this provision as of January 1, 2003.

This bill would extend the repeal date of the provision from January 1, 2003, to January 1, 2006.

Existing law authorizes the board of supervisors of a county that contracted with the State Department of Health Services pursuant to a specified provision of law during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, to elect to participate in the County Medical Services Program (CMSP) for the state administration of health care services to eligible persons in the county. Existing law specifies a formula under which counties and the state share the risk for cost increases of the CMSP not funded through other sources.

This bill would revise this formula.

Existing law authorizes, until January 1, 2003, a county to establish a County Medical Services Program Governing Board, with a specified membership, to administer the CMSP.

This bill would extend the operation of these provisions until January 1, 2008.

Existing law requires that the contract between the State Department of Health Services and the County Medical Services Program Governing Board require that the state provide a designated minimum level of administrative support to the CMSP.

This bill would require, instead, that the County Medical Services Program Governing Board reimburse up to \$3,500,000 for the state costs of providing administrative support to the CMSP.

Existing law establishes the County Medical Services Program Account in the County Health Services Fund, which is continuously appropriated, and specifies the purposes for which moneys in the account may be used.

This bill would provide that moneys in the account also may be used to reimburse the State Department of Health Services for state costs of providing administrative support to the CMSP, thereby making an appropriation.



Existing law requires the State Department of Health Services, in conjunction with the State Department of Social Services, to implement a simplified eligibility process as part of the Food Stamp program to expedite Medi-Cal program and Healthy Families Program enrollment.

This bill, instead, would provide that these provisions shall be implemented on and after July 1, 2003, but only if and to the extent that federal financial participation is available.

This bill would authorize the State Department of Health Services to adopt emergency regulations to implement the applicable provisions of this bill in accordance with the rulemaking provisions of the Administrative Procedure Act.

The bill would prohibit the State Department of Health Services from recouping any overpayment made to a provider before October 1, 2002, under a specified provision of the Medi-Cal Act for ambulance transport services, if the overpayment is not due to the fault of the provider. It would also add to the requirements of the State Department of Health Services with regard to completing the design and implementation of the Children's Medical Services Network (CMS Net).

The bill would require the California Health and Human Services Agency to develop a comprehensive plan that responds to the decision of the United States Supreme Court in *Olmstead v. L.C.* and that describes the actions that California may take to improve its long-term care system so that its residents have available an array of community care options that allow them to avoid unnecessary institutionalization.

This bill would specify requirements of the State Department of Developmental Services related to the use of funds appropriated in Item 4300-101-0001 of the Budget Act of 2002 pertaining to regional centers.

The bill would provide that of the amounts appropriated in Item 4260-111-0001 of the Budget Act of 2002 from the Hospital Services Account, the Physician Services Account, and the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund, \$24,803,000 shall be administered and allocated for the 2002–03 fiscal year, as provided in the bill, for distribution through the California Healthcare for Indigents Program and the rural health services program.

The bill would provide that the unencumbered balances of the amounts appropriated in Item 4260-001-0589 of Chapter 50 of the Statutes of 1999, Item 4260-001-0589 of Chapter 52 of the Statutes of 2000, and Item 4260-001-0589 of Chapter 106 of the Statutes of 2001 are reappropriated and shall be available for encumbrance and expenditure until July 30, 2005, thereby making an appropriation.

This bill, in order to implement changes in the level of funding for Medi-Cal services in the Budget Act of 2002, would require the Director of Health Services to eliminate, with specified exceptions, all provider



rate increases that were provided, effective August 1, 2000, for services rendered in the Medi-Cal program. The bill would define “provider” for purposes of this requirement.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 4426 of the Business and Professions Code is amended to read:

4426. The State Department of Health Services shall conduct a study of the adequacy of Medi-Cal pharmacy reimbursement rates including the cost of providing prescription drugs and services.

SEC. 2. Section 4427 of the Business and Professions Code is repealed.

SEC. 3. Section 49557.2 of the Education Code is amended to read:

49557.2. (a) (1) Effective July 1, 2003, at the option of the school district or county superintendent, and to the extent necessary to implement Section 14005.41 of the Welfare and Institutions Code, the following information may be incorporated into the School Lunch Program application packet or notification of eligibility for the School Lunch Program using simple and culturally appropriate language:

(A) A notification that if a child qualifies for free school lunches, then the child may qualify for free or reduced-cost health coverage.

(B) A request for the applicant’s consent for the child to participate in the Medi-Cal program, if eligible for free school lunches, and to have the information on the school lunch application shared with the entity designated by the State Department of Health Services to make an accelerated determination and the local agency that determines eligibility under the Medi-Cal program.

(C) A notification that the school district will not forward the school lunch application to the entity designated by the State Department of



Health Services to make an accelerated determination and the local agency that determines eligibility under the Medi-Cal program, without the consent of the child's parent or guardian.

(D) A notification that the school lunch application is confidential and, with the exception of forwarding the information for use in health program enrollment upon the consent of the child's parent or guardian, the school district will not share the information with any other governmental agency, including the federal Immigration and Naturalization Service and the Social Security Administration.

(E) A notification that the school lunch application information will only be used by the entity designated by the State Department of Health Services to make an accelerated determination and the state and local agencies that administer the Medi-Cal program for purposes directly related to the administration of the program and will not be shared with other government agencies, including the Immigration and Naturalization Service and the Social Security Administration for any purpose other than the administration of the Medi-Cal program.

(F) Information regarding the Medi-Cal program, including available services, program requirements, rights and responsibilities, and privacy and confidentiality requirements.

(2) The State Department of Education, in consultation with school districts, county superintendents of schools, consumer advocates, counties, the State Department of Health Services, and other stakeholders, shall make recommendations regarding the School Lunch Program application, on or before February 1, 2003. The recommendations shall include specific changes to the School Lunch Program application materials as necessary to implement Section 14005.41 of the Welfare and Institutions Code, information for staff as to how to implement the changes, and a description of the process by which information on the School Lunch Program application will be shared with the county, as the local agency that determines eligibility under the Medi-Cal program.

(b) (1) Effective July 1, 2003, school districts and county superintendents of schools may implement a process to share information provided on the entity designated by the State Department of Health Services to make an accelerated determination and the School Lunch Program application with the entity designated by the State Department of Health Services to make an accelerated determination and the local agency that determines eligibility under the Medi-Cal program, and shall share this information with those entities, if the applicant consents to that sharing of information. This information may be shared electronically, physically, or through whatever method is determined appropriate.



(2) Each school district or county superintendent that chooses to share information pursuant to this subdivision shall enter into a memorandum of understanding with the local agency that determines eligibility under the Medi-Cal program, that sets forth the roles and responsibilities of each agency and the process to be used in sharing the information.

(3) The local agency that determines eligibility under the Medi-Cal program shall only use information provided by applicants on the school lunch application for purposes directly related to the administration of the Medi-Cal program.

(4) After school districts share information regarding the school lunch application with the entity designated by the State Department of Health Services to make an accelerated determination and the local agency that determines eligibility under the Medi-Cal program, for the purpose of determining Medi-Cal program eligibility, the local agency and the school district shall not share information about school lunch participation or the Medi-Cal program eligibility information with each other unless specifically authorized under other provisions of law.

SEC. 4. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars (\$25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to any applicant prior to receiving payment in full for all amounts charged pursuant to this subdivision.

(b) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances and complaints including maintaining a toll-free number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead, reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year. The amount paid by each plan, except a plan offering only specialized health care service plan contracts, shall be twelve thousand five hundred



dollars (\$12,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	\$0 + 65 cents for each enrollee
25,001 to 75,000	\$16,250 + 53 cents for each enrollee in excess of 25,000
75,001 to 150,000	\$42,750 + 50 cents for each enrollee in excess of 75,000
150,001 to 300,000	\$80,250 + 47 cents for each enrollee in excess of 150,000
over 300,000	\$150,750 + 45 cents for each enrollee in excess of 300,000

Plans offering only specialized health care service plan contracts shall pay seven thousand five hundred dollars (\$7,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	\$0 + 48 cents for each enrollee
25,001 to 75,000	\$12,000 + 36 cents for each enrollee in excess of 25,000
75,001 to 150,000	\$30,000 + 30 cents for each enrollee in excess of 75,000
150,001 to 300,000	\$52,500 + 26 cents for each enrollee in excess of 150,000
over 300,000	\$91,500 + 24 cents for each enrollee in excess of 300,000

The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the commissioner determines that the method used for determining the estimate was not reasonable.

In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.



(c) Each licensed plan shall also pay two thousand dollars (\$2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent (\$.0048) for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) The director by notice to all licensed plans on or before September 15 of each year, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses as set forth in this section and subdivision (b) of Section 1341.4 for the 2000–01, 2001–02, and 2002–03 fiscal years. Any plan that did not pay its assessment as required under this subdivision for the 2001–02 fiscal year shall be assessed the amount due for the 2001–02 fiscal year in the 2002–03 fiscal year, in addition to the amount due in the 2002–03 fiscal year. The assessment pursuant to this subdivision is separate and independent of the assessment in subdivision (b), and may not be aggregated for the purposes of limitation or otherwise with the assessment in subdivision (b). The assessment pursuant to this subdivision is not subject to the limitations imposed on assessments pursuant to Section 1356.1. In imposing an assessment pursuant to this subdivision the director shall levy on each plan an amount determined by the director using the categories of plans in the schedules set forth in subdivision (b). The assessment shall be paid in full or in two equal installments, as determined by the department. On July 1, 2003, and thereafter, the director may raise the assessment limit pursuant to subdivision (b) to incorporate annual expenditure levels set forth in this subdivision.

(f) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

SEC. 5. Section 1797.199 of the Health and Safety Code is amended to read:

1797.199. (a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).



(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section 100257 of Title 22 of the California Code of Regulations. However, the local EMS agency's report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center's emergency department without being admitted to the hospital unless the nonadmission is due to the patient's death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivisions (j) and (o), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency's jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency's area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The local EMS agency may utilize a grant-based system, a reimbursement-based system, or other appropriate methodology to comply with this section. Local EMS agencies shall take



the following factors into consideration when determining the distribution amounts for each trauma center:

(1) The volume of uninsured trauma patients treated at the trauma center.

(2) The existence of a high percentage of uninsured trauma patients relative to the total number of trauma patients treated at the trauma center.

(3) The acuity mix of uninsured trauma patients treated at the trauma center.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority. The authority shall deposit any such funds into the reserve described in subdivision (j). In the case of a local EMS agency that distributes funds using a reimbursement or fee-for-service system, a trauma center that ceases functioning as a trauma center shall only be required to pay back a pro rata portion of the minimum distributed as described in subdivision (i).

(i) Notwithstanding subdivision (f), the local EMS agency shall provide from the funds that the local EMS agency receives from the authority a minimum amount of one hundred fifty thousand dollars (\$150,000) to each Level I or Level II trauma center to assist those centers in ensuring trauma center viability. The local EMS agency shall provide a Level III trauma center a minimum amount of fifty thousand dollars (\$50,000) for this purpose. If a local EMS agency's distribution pursuant to subdivision (e) is less than the amount necessary for each trauma center within the local EMS agency's jurisdiction to receive the minimum amount provided by this subdivision, the authority shall include in its distribution to the agency an additional amount of funds necessary to make up the minimum amount pursuant to paragraph (1) of subdivision (j) plus 1 percent of the added amount for local EMS agency administrative costs. Based upon qualifying patient volume figures and the distribution factors established in subdivision (f), a trauma center



designated as a Level IV may receive funding as determined appropriate by the local EMS agency.

(j) Notwithstanding subdivision (e), the authority shall reserve 6 percent of any funds appropriated to the Trauma Care Fund for distribution during the same fiscal year. The authority may spend these funds for the purposes specified in paragraphs (1) to (3), inclusive.

(1) To provide to a local EMS agency, the amount that the agency needs to make up the full minimum amount specified in subdivision (i).

(2) To provide a minimum amount to a trauma center that was not designated on July 1 of the fiscal year as specified in subdivision (e) but which becomes designated by January 1 of any fiscal year in which funds are being distributed pursuant to this section. In the case of such a newly designated center, the minimum distribution shall equal one-half of the minimum distribution described in subdivision (i), provided the local EMS agency makes an application to the authority for this purpose by February 1 of the same fiscal year.

(3) To the extent that there are funds in the reserve after the distributions provided by paragraphs (1) and (2) of this subdivision, to provide additional amounts to a local EMS agency where the distribution under subdivision (f) does not provide an accurate reflection of its total trauma volume. Any local EMS agency that believes the distribution under subdivision (f) does not provide an accurate accounting of its total trauma patient volume may make application to the authority for an adjustment.

(A) The application shall state the reason for the request and shall include supporting data.

(B) The authority shall consider all applications submitted pursuant to this paragraph and received by February 1 of the fiscal year.

(C) Based on the application and its supporting information, the authority shall determine the amount, if any, that the local agency should receive in addition to the amounts specified in subdivision (e) and shall allocate an appropriate amount of the reserve in accordance with its determination.

(k) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.



(l) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years, except that the minimum distribution specified in subdivision (i) shall be provided to the extent that moneys are available in the fund.

(m) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(n) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(o) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars (\$280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process.

SEC. 5.5. Section 26157 is added to the Health and Safety Code, to read:

26157. (a) The department may receive voluntary contributions to support the department's activities in providing guidance, developing standards and guidelines and permissible exposure limits, and adopting regulations relating to indoor mold hazards, including, but not limited to, duties included under this chapter.

(b) The contributions shall be deposited in the Public Health Protection from Indoor Mold Hazards Fund, which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated to the department without regard to fiscal years and shall be used to support the department's activities in providing guidance, developing standards and guidelines and permissible exposure limits, and adopting regulations



relating to indoor mold hazards, including, but not limited to, duties included under this chapter to the extent that funding is available.

SEC. 6. Section 53300 of the Health and Safety Code is amended to read:

53300. (a) No more than 10 percent of the amount appropriated in a fiscal year for the purposes of this chapter may be used for state administration of this chapter, including evaluation and technical assistance. Technical assistance shall include, but is not limited to, assisting with collaborations, providing information, and convening training workshops. The Legislature shall be notified of the administrative costs of this program pursuant to Section 28 of the Budget Act.

(b) Notwithstanding the allocation of funds in the Budget Act of 2000 for the supportive housing initiative to the local assistance Item 4440-101-0001, up to 10 percent of the funds may be spent for administrative costs, as defined in subdivision (a).

(c) Notwithstanding any other provision of law, the lead agency shall make all grant awards from funds allocated in the Budget Act of 2001 for the supportive housing initiative no later than June 30, 2002, and shall expend the funds allocated for those grants no later than June 30, 2005, except for grants awarded for housing costs, as specified in paragraph (1) of subdivision (b) of Section 53275.

SEC. 7. Section 100171 of the Health and Safety Code is amended to read:

100171. Notwithstanding any other provision of law, whenever the department is authorized or required by statute, regulation, due process (14th amendment, United States Constitution; subdivision (a) of Section 7 of Article I, California Constitution), or a contract, to conduct an adjudicative hearing leading to a final decision of the director or the department, the following shall apply:

(a) The proceeding shall be conducted pursuant to the administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except as specified in this section.

(b) Notwithstanding Section 11502 of the Government Code, whenever the department conducts a hearing under Chapter 4.5 (commencing with Section 11400) or Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, the hearing shall be conducted before an administrative law judge selected by the department and assigned to a hearing office that complies with the procedural requirements of Chapter 4.5 (commencing with Section 11400) of Part 1 of Division 3 of Title 2 of the Government Code.



(c) (1) Notwithstanding Section 11508 of the Government Code, whenever the department conducts a hearing under Chapter 4.5 (commencing with Section 11400) or Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, the time and place of the hearing shall be determined by the staff assigned to the hearing office of the department, except as provided in paragraph (2) or unless the department by regulation specifies otherwise.

(2) Formal hearings requested by institutional Medi-Cal providers and health facilities shall be held in Sacramento.

(d) (1) Unless otherwise specified in this section, the following sections of the Government Code shall apply to any adjudicative hearing conducted by the department only if the department has not, by regulation, specified an alternative procedure for the particular type of hearing at issue: Section 11503 (relating to accusations), Section 11504 (relating to statements of issues), Section 11505 (relating to the contents of the statement to respondent), Section 11506 (relating to the notice of defense), Section 11507.6 (relating to discovery rights and procedures), Section 11508 (relating to the time and place of hearings), and Section 11516 (relating to amendment of accusations).

(2) Any alternative procedure specified by the department in accordance with this subdivision shall conform to the purpose of the Government Code provision it replaces insofar as it is possible to do so consistent with the specific procedural requirements applicable to the type of hearing at issue.

(3) Any alternative procedures adopted by the department under this subdivision shall not diminish the amount of notice given of the issues to be heard by the department or deprive appellants of the right to discovery suitable to the particular proceedings. Except as specified in paragraph (2) of subdivision (c), modifications of timeframes or of the place of hearing made by regulation may not lengthen timeframes within which the department is required to act nor require hearings to be held at a greater distance from the appellant's place of residence or business than is the case under the otherwise applicable Government Code provision.

(e) The specific timelines specified in Section 11517 of the Government Code shall not apply to any adjudicative hearing conducted by the department to the extent that the department has, by regulation, specified different timelines for the particular type of hearing at issue.

(f) In the case of any adjudicative hearing conducted by the department, "transcript," as used in subdivision (c) of Section 11517 of the Government Code, shall be deemed to include any alternative form of recordation of the oral proceedings, including, but not limited to, an audiotape.



(g) Pursuant to Section 11415.50 of the Government Code, the department may, by regulation, provide for any appropriate informal procedure to be used for an informal level of review that does not itself lead to a final decision of the department or the director. The procedures specified in Article 10 (commencing with Section 11445.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code shall not apply to any such an informal level of review. Informal conferences concerning appeals by institutional Medi-Cal providers and health facilities may be held in Sacramento or Los Angeles.

(h) Notwithstanding any other provision of law, any adjudicative hearing conducted by the department that is conducted pursuant to a federal statutory or regulatory requirement that contains specific procedures may be conducted pursuant to those procedures to the extent they are inconsistent with the procedures specified in this section.

(i) Nothing in this section shall apply to a fair hearing involving a Medi-Cal beneficiary insofar as the hearing is, by agreement or otherwise, heard before an administrative law judge employed by the State Department of Social Services, or insofar as the hearing is being held pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code in connection with services provided by the State Department of Developmental Services under applicable federal medicaid waivers. Nothing in this subdivision shall be interpreted as abrogating the authority of the State Department of Health Services as the single state agency under the state medicaid plan.

(j) Nothing in this provision shall supersede express provisions of law that apply to any hearing that is not adjudicative in nature or that does not involve due process rights specific to an individual or specific individuals, as opposed to the general public or a segment of the general public.

SEC. 8. Article 6 (commencing with Section 101315) is added to Chapter 3 of Part 3 of Division 101 of the Health and Safety Code, to read:

Article 6. Federal Funding for Bioterrorism Preparedness and other
Public Health Threats

101315. (a) Federal funding received by the State Department of Health Services for bioterrorism preparedness and emergency response is subject to appropriation in the annual Budget Act.

(b) This article shall govern the purposes for which federal funding may be allocated and expended by local health jurisdictions for the prevention of, and response to, bioterrorist attacks and other public



health emergencies pursuant to the federally approved collaborative state-local plan.

(c) A local health jurisdiction shall be ineligible to receive funding from appropriations made for purposes of this article when that local health jurisdiction receives directly or through another local jurisdiction federal funding for the same purposes. Moneys appropriated in the annual Budget Act for purposes of this article that would have been allocated to a local health jurisdiction that is ineligible, pursuant to this subdivision, to receive funding shall be allocated, as provided in Section 101317, among the remaining local health jurisdictions that are eligible.

(d) Funds appropriated for the purposes of this article shall not be used to supplant funding for existing levels of service and shall only be used for purposes specified in Section 101317.

101317. (a) For purposes of this article, allocations shall be made to the administrative bodies of qualifying local health jurisdictions described as public health administrative organizations in Section 101185, and pursuant to Section 101315, in the following manner:

(1) (A) For the 2003–04 fiscal year and subsequent fiscal years, to the administrative bodies of each local health jurisdiction, a basic allotment of one hundred thousand dollars (\$100,000), subject to the availability of funds appropriated in the annual Budget Act or some other act.

(B) For the 2002–03 fiscal year, the basic allotment of one hundred thousand dollars (\$100,000) shall be reduced by the amount of federal funding allocated as part of a basic allotment for the purposes of this article to local health jurisdictions in the 2001–02 fiscal year.

(2) (A) Except as provided in subdivision (c), after determining the amount allowed for the basic allotment as provided in paragraph (1), the balance of the annual Budget Act appropriation for purposes of this article, if any, shall be allotted on a per capita basis to the administrative bodies of each local health jurisdiction in the proportion that the population of that local health jurisdiction bears to the population of all eligible local health jurisdictions of the state.

(B) The population estimates used for the calculation of the per capita allotment pursuant to subparagraph (A) shall be based on the Department of Finance’s E-1 Report, “City/County Populations Estimates with Annual Percentage Changes” as of January 1 of the previous year. However, if within a local health jurisdiction there are one or more city health jurisdictions, the local health jurisdiction shall subtract the population of the city or cities from the local health jurisdiction total population for purposes of calculating the per capita total.



(b) If the amounts appropriated in the annual Budget Act are insufficient to fully fund the allocations specified in subdivision (a), the department shall prorate and adjust each local health jurisdiction's allocation so that the total amount allocated equals the amount appropriated.

(c) For the 2002–03 fiscal year and subsequent fiscal years, where the federally approved collaborative state-local plan identifies an allocation method, other than the basic allotment and per capita method described in subdivision (a), for specific funding to a local public health jurisdiction, including, but not limited to, funding laboratory training, chemical and nuclear terrorism preparedness, and information technology approaches, that funding shall be paid to the administrative bodies of those local health jurisdictions in accordance with the federally approved collaborative state-local plan for bioterrorism preparedness and other public health threats in the state.

(d) Funds appropriated pursuant to the annual Budget Act for allocation to local health jurisdictions pursuant to this article shall be disbursed quarterly to local health jurisdictions beginning July 1, 2002, using the following process:

(1) Each fiscal year, upon the submission of an application for funding by the administrative body of a local health jurisdiction, the department shall make the first quarterly payment to each eligible local health jurisdiction. That application shall include a plan and budget for the local program that is in accordance with the department's plans and priorities for bioterrorism preparedness and response, and other public health threats and emergencies, and a certification by the chairperson of the board of supervisors or the mayor of a city with a local health department that the funds received pursuant to this article will not be used to supplant other funding sources in violation of subdivision (d) of Section 101315.

(2) The department shall establish procedures and a format for the submission of the local health jurisdiction's plan and budget. The local health jurisdiction's plan shall be consistent with the department's plans and priorities for bioterrorism preparedness and response, and other public health threats and emergencies, in accordance with requirements specified in the department's federal grant award. Payments to local health jurisdictions beyond the first quarter shall be contingent upon the approval of the department of the local health jurisdiction's plan and the local health jurisdiction's progress in implementing the provisions of the local health jurisdiction's plan, as determined by the department.

(3) If a local health jurisdiction does not apply or submits a noncompliant application for its allocation, those funds provided under



this article may be redistributed according to subdivision (a) to the remaining local health jurisdictions.

(e) Funds shall be used for activities to improve and enhance local health jurisdictions' preparedness for and response to bioterrorism and other public health threats and emergencies, including laboratory training and information technology, and for any other purposes, as determined by the department, that are consistent with the purposes for which the funds were appropriated.

(f) Any local health jurisdiction that receives funds pursuant to this article shall deposit them in a special Local Public Health Preparedness Trust Fund established solely for this purpose before transferring or expending the funds for any of the uses allowed pursuant to this article. The interest earned on moneys in the fund shall accrue to the benefit of the fund and shall be expended for the same purposes as other moneys in the fund.

(g) (1) A local health jurisdiction that receives funding pursuant to this article shall submit reports that display cost data and the activities funded by moneys deposited in its Local Public Health Preparedness Trust Fund to the department on a regular basis in a form and according to procedures prescribed by the department.

(2) The department, in consultation with local health jurisdictions, shall develop required content for the reports required under paragraph (1), which shall include, but shall not be limited to, data and information needed to implement this article and to satisfy federal reporting requirements. The chairperson of the board of supervisors or the mayor of a city with a local health department shall certify the accuracy of the reports and that the moneys appropriated for the purposes of this article have not been used to supplant other funding sources.

(h) The administrative body of a local health jurisdiction may enter into a contract with the department and the department may enter into a contract with that local health jurisdiction for the department to administer all or a portion of the moneys allocated to the local health jurisdiction pursuant to this article.

(i) The department may recoup from a local health jurisdiction any moneys allocated pursuant to this article that are unspent or that are not expended for purposes specified in subdivision (d). The department may also recoup funds expended by a local health jurisdiction in violation of subdivision (d) of Section 101315. The department may withhold quarterly payments of moneys to a local health jurisdiction if the local health jurisdiction is not in compliance with this article or the terms of that local health jurisdiction's plan as approved by the department. Before any funds are recouped or withheld from a local health jurisdiction, the department shall meet with local health officials to



discuss the status of the unspent moneys or the disputed use of the funds or both.

(j) Moneys made available for bioterrorism preparedness pursuant to this article in the 2001–02 fiscal year shall be available for expenditure and encumbrance until June 30, 2003. Moneys made available for bioterrorism preparedness pursuant to this article from July 1, 2002, to August 30, 2003, inclusive, shall be available for expenditure and encumbrance until August 30, 2004, subject to extension of the federal grant authority.

101319. Due to the need to rapidly implement, and to provide local health jurisdictions with timely funding for the purposes of, this article, funds appropriated in the annual Budget Act for purposes of this article for the 2002–03 fiscal year and subsequent fiscal years shall be allocated through the use of agreements, which shall not be subject to Part 2 (commencing with Section 10100) of the Public Contract Code.

SEC. 9. Section 104188 is added to the Health and Safety Code, to read:

104188. The maximum indirect cost rate that may be charged on any cancer research program grant awarded to any institution under this article shall not be more than 25 percent of the institution's direct costs.

SEC. 10. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) To the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS). The director shall develop, maintain, and update as necessary a list of drugs to be provided under this program. Drugs on the list shall include, but not be limited to, the drugs zidovudine (AZT) and aerosolized pentamidine.

(b) The director may grant funds to a county public health department through standard agreements to administer this program in that county. To maximize the recipients' access to drugs covered by this program, the director shall urge the county health department in counties granted these funds to decentralize distribution of the drugs to the recipients.

(c) The director shall establish a rate structure for reimbursement for the cost of each drug included in the program. Rates shall not be less than the actual cost of the drug. However, the director may purchase a listed drug directly from the manufacturer and negotiate the most favorable bulk price for that drug.

(d) Manufacturers of the drugs on the list shall pay the department a rebate equal to the rebate that would be applicable to the drug under



Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) plus an additional rebate to be negotiated by each manufacturer with the department, except that no rebates shall be paid to the department under this section on drugs for which the department has received a rebate under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) or that have been purchased on behalf of county health departments or other eligible entities at discount prices made available under Section 256b of Title 42 of the United States Code.

(e) The department shall submit an invoice, not less than two times per year, to each manufacturer for the amount of the rebate required by subdivision (d).

(f) Drugs may be removed from the list for failure to pay the rebate required by subdivision (d), unless the department determines that removal of the drug from the list would cause substantial medical hardship to beneficiaries.

(g) The department may adopt emergency regulations to implement amendments to this chapter made during the 1997–98 Regular Session, in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(h) Reimbursement under this chapter shall not be made for any drugs that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision where exemption would represent a cost savings to the state.

SEC. 11. Section 124030 of the Health and Safety Code is amended to read:

124030. As used in this article and Section 120475:

(a) “State board” means the State Maternal, Child, and Adolescent Health Board.

(b) “Department” means the department.

(c) “Director” means the director.

(d) “Governing body” means the county board of supervisors or boards of supervisors in the case of counties acting jointly.

(e) “Local board” means local maternal, child, and adolescent health board.



(f) “Local health jurisdiction” means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of Section 101185.

(g) “Child Health and Disability Prevention provider” or “CHDP provider” means any of the following, if approved for participation in the Child Health and Disability Prevention program by the community Child Health and Disability program director in accordance with program standards and as certified by the department:

(1) A physician licensed to practice medicine in California.

(2) A family nurse practitioner certified pursuant to Sections 2834 and 2836 of the Business and Professions Code.

(3) A pediatric nurse practitioner certified pursuant to Sections 2834 and 2836 of the Business and Professions Code.

(4) A primary care center, clinic, or other public or private agency or organization that provides outpatient health care services.

(5) A physicians’ group.

(6) A licensed clinical laboratory.

SEC. 12. Section 124033 is added to the Health and Safety Code, to read:

124033. (a) Commencing July 1, 2003, all applications for services under the Child Health and Disability Prevention program shall be filed electronically in accordance with subdivision (b) of Section 14011.7 of the Welfare and Institutions Code.

(b) To implement the program described in subdivisions (b) to (e), inclusive, of Section 14011.7 of the Welfare and Institutions Code for the use of an electronic application for the Child Health and Disability Prevention program and for preenrollment into the Medi-Cal program or the Healthy Families Program, the following shall apply:

(1) The department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program’s fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement.

(2) Contracts, including the Medi-Cal program fiscal intermediary contract for the Child Health and Disability Prevention Program, including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.



SEC. 13. Section 124040 of the Health and Safety Code is amended to read:

124040. (a) The governing body of each county or counties shall establish a community child health and disability prevention program for the purpose of providing early and periodic assessments of the health status of children in the county or counties by July 1, 1974. However, this shall be the responsibility of the department for all counties that contract with the state for health services. Contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, provided the option is exercised prior to the beginning of each fiscal year. Each plan shall include, but is not limited to, the following requirements:

- (1) Outreach and educational services.
- (2) Agreements with public and private facilities and practitioners to carry out the programs.
- (3) Health screening and evaluation services for all children including a physical examination, immunizations appropriate for the child's age and health history, and laboratory procedures appropriate for the child's age and population group performed by, or under the supervision or responsibility of, a physician licensed to practice medicine in California or by a certified family nurse practitioner or a certified pediatric nurse practitioner.
- (4) Referral for diagnosis or treatment when needed, including, for all children eligible for Medi-Cal, referral for treatment by a provider participating in the Medi-Cal program of the conditions detected, and methods for assuring referral is carried out.
- (5) Recordkeeping and program evaluations.
- (6) The health screening and evaluation part of each community child health and disability prevention program plan shall include, but is not limited to, the following for each child:
 - (A) A health and development history.
 - (B) An assessment of physical growth.
 - (C) An examination for obvious physical defects.
 - (D) Ear, nose, mouth, and throat inspection, including inspection of teeth and gums, and for all children three years of age and older who are eligible for Medi-Cal, referral to a dentist participating in the Medi-Cal program.
 - (E) Screening tests for vision, hearing, anemia, tuberculosis, diabetes, and urinary tract conditions.
- (7) An assessment of nutritional status.
- (8) An assessment of immunization status.



(9) Where appropriate, testing for sickle-cell trait, lead poisoning, and other tests that may be necessary to the identification of children with potential disabilities requiring diagnosis and possibly treatment.

(10) For all children eligible for Medi-Cal, necessary assistance with scheduling appointments for services and with transportation.

(b) Dentists receiving referrals of children eligible for Medi-Cal under this section shall employ procedures to advise the child's parent or parents of the need for and scheduling of annual appointments.

(c) Standards for procedures to carry out health screening and evaluation services and to establish the age at which particular tests should be carried out shall be established by the director. At the discretion of the department, these health screening and evaluation services may be provided at the frequency provided under the Healthy Families Program and permitted in managed care plans providing services under the Medi-Cal program, and shall be contingent upon appropriation in the annual Budget Act. Immunizations may be provided at the frequency recommended by the Committee on Infectious Disease of the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(d) Each community child health and disability prevention program shall, pursuant to standards set by the director, establish a record system that contains a health case history for each child so that costly and unnecessary repetition of screening, immunization and referral will not occur and appropriate health treatment will be facilitated as specified in Section 124085.

SEC. 14. Section 124120 of the Health and Safety Code is amended to read:

124120. The department may conduct a community outreach and awareness campaign to inform medical providers, pregnant women, and the families of newborns and infants on the availability of the newborn hearing screening program and the value of early hearing testing. The outreach and awareness campaign shall be conducted by an independent contractor.

SEC. 15. Section 124250 of the Health and Safety Code is amended to read:

124250. (a) The following definitions shall apply for purposes of this section:

(1) "Domestic violence" means the infliction or threat of physical harm against past or present adult or adolescent female intimate partners, and shall include physical, sexual, and psychological abuse against the woman, and is a part of a pattern of assaultive, coercive, and controlling



behaviors directed at achieving compliance from or control over, that woman.

(2) “Shelter-based” means an established system of services where battered women and their children may be provided safe or confidential emergency housing on a 24-hour basis, including, but not limited to, hotel or motel arrangements, haven, and safe houses.

(3) “Emergency shelter” means a confidential or safe location that provides emergency housing on a 24-hour basis for battered women and their children.

(b) The Maternal and Child Health Branch of the State Department of Health Services shall administer a comprehensive shelter-based services grant program to battered women’s shelters pursuant to this section.

(c) The Maternal and Child Health Branch shall administer grants, awarded as the result of a request for application process, to battered women’s shelters that propose to maintain shelters or services previously granted funding pursuant to this section, to expand existing services or create new services, and to establish new battered women’s shelters to provide services, in any of the following four areas:

(1) Emergency shelter to women and their children escaping violent family situations.

(2) Transitional housing programs to help women and their children find housing and jobs so that they are not forced to choose between returning to a violent relationship or becoming homeless. The programs may offer up to 18 months of housing, case management, job training and placement, counseling, support groups, and classes in parenting and family budgeting.

(3) Legal and other types of advocacy and representation to help women and their children pursue the appropriate legal options.

(4) Other support services for battered women and their children.

(d) (1) The Maternal and Child Health Branch of the State Department of Health Services shall conduct a minimum of one site visit per grant term to each agency funded to provide shelter-based services to battered women and their children. The purpose of the site visit shall be a performance assessment of, and technical assistance for, each agency visited. The performance assessment shall include, but need not be limited to, a review of all of the following:

(A) Progress in meeting program goals and objectives.

(B) Agency organization and facilities.

(C) Personnel policies, files, and training.

(D) Recordkeeping, budgeting, and expenditures.

(E) Documentation, data collection, and client confidentiality.



(2) Subsequent to each site visit conducted under paragraph (1), the Maternal and Child Health Branch shall provide a written report to the agency summarizing the agency's performance, any deficiencies noted, and any corrective action needed.

(3) Where an agency receives funding from both the Maternal and Child Health Branch of the State Department of Health Services and the Domestic Violence Branch of the Office of Criminal Justice Planning during any grant cycle, the Maternal and Child Health Branch and the Domestic Violence Branch shall, to the extent feasible, coordinate agency site visits and share performance assessment data with the goal of improving efficiency, eliminating duplication, and reducing administrative costs.

(e) In implementing the grant program pursuant to this section, the State Department of Health Services shall consult with an advisory council that shall remain in existence until January 1, 2006. The council shall be composed of not to exceed 13 voting members and two nonvoting members appointed as follows:

(1) Seven members appointed by the Governor.

(2) Three members appointed by the Speaker of the Assembly.

(3) Three members appointed by the Senate Committee on Rules.

(4) Two nonvoting ex officio members who shall be Members of the Legislature, one appointed by the Speaker of the Assembly and one appointed by the Senate Committee on Rules. Any Member of the Legislature appointed to the council shall meet with, and participate in the activities of, the council to the extent that participation is not incompatible with his or her position as a Member of the Legislature.

The membership of the council shall consist of domestic violence advocates, battered women service providers, and representatives of women's organizations, law enforcement, and other groups involved with domestic violence. At least one-half of the council membership shall consist of domestic violence advocates or battered women service providers from organizations such as the California Alliance Against Domestic Violence.

It is the intent of the Legislature that the council membership reflect the ethnic, racial, cultural, and geographic diversity of the state.

(f) The department shall collaborate closely with the council in the development of funding priorities, the framing of the Request for Proposals, and the solicitation of proposals.

(g) (1) The Maternal and Child Health Branch of the State Department of Health Services shall administer grants, awarded as the result of a request for application process, to agencies to conduct demonstration projects to serve battered women, including, but not limited to, creative and innovative service approaches, such as



community response teams and pilot projects to develop new interventions emphasizing prevention and education, and other support projects identified by the advisory council.

(2) For purposes of this subdivision, “agency” means a state agency, a local government, a community-based organization, or a nonprofit organization.

(h) It is the intent of the Legislature that services funded by this program include services in underserved and ethnic and racial communities. Therefore, the Maternal and Child Health Branch of the State Department of Health Services shall do all of the following:

(1) Fund shelters pursuant to this section that reflect the ethnic, racial, economic, cultural, and geographic diversity of the state.

(2) Target geographic areas and ethnic and racial communities of the state whereby, based on a needs assessment, it is determined that no shelter-based services exist or that additional resources are necessary.

(i) The director may award additional grants to shelter-based agencies when it is determined that there exists a critical need for shelter or shelter-based services.

(j) As a condition of receiving funding pursuant to this section, battered women’s shelters shall do all of the following:

(1) Provide matching funds or in-kind contributions equivalent to not less than 20 percent of the grant they would receive. The matching funds or in-kind contributions may come from other governmental or private sources.

(2) Ensure that appropriate staff and volunteers having client contact meet the definition of “domestic violence counselor” as specified in subdivision (a) of Section 1037.1 of the Evidence Code. The minimum training specified in paragraph (2) of subdivision (a) of Section 1037.1 of the Evidence Code shall be provided to those staff and volunteers who do not meet the requirements of paragraph (1) of subdivision (a) of Section 1037.1 of the Evidence Code.

SEC. 15.5. Section 124977 of the Health and Safety Code is amended to read:

124977. (a) It is the intent of the Legislature that, unless otherwise specified, the program carried out pursuant to this chapter be fully supported from fees collected for services provided by the program.

(b) (1) The department shall charge a fee to all payers for any tests or activities performed pursuant to this chapter. The amount of the fee shall be established by regulation and periodically adjusted by the director in order to meet the costs of this chapter. Notwithstanding any other provision of law, any fees charged for screening and followup services provided to Medi-Cal eligible persons, health care service plan enrollees, or persons covered by disability insurance policies, shall be



paid in full directly to the Genetic Disease Testing Fund, subject to all terms and conditions of each enrollee's or insured's health care service plan or insurance coverage, whichever is applicable, including, but not limited to, copayments and deductibles applicable to these services, and only if these copayments, deductions, or limitations are disclosed to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(2) The department shall expeditiously undertake all steps necessary to implement the fee collection process, including personnel, contracts, and data processing, so as to initiate the fee collection process at the earliest opportunity. In no event shall a hospital be charged a fee for any test performed pursuant to this chapter on or after July 1, 2001.

(3) Paragraphs (1) and (2) shall be inoperative for services provided after June 30, 2002.

(4) Effective for services provided on and after July 1, 2002, the department shall charge a fee to the hospital of birth, or, for births not occurring in a hospital, to families of the newborn, for newborn screening and followup services. The hospital of birth and families of newborns born outside the hospital shall make payment in full to the Genetic Disease Testing Fund. The amount of the fee shall be established by regulation and periodically adjusted by the director in order to meet the costs of providing services under this chapter. The department shall not charge or bill Medi-Cal beneficiaries for services provided under this chapter.

(c) (1) The Legislature finds that timely implementation of changes in genetic screening programs and continuous maintenance of quality statewide services requires expeditious regulatory and administrative procedures, including policies and procedures developed pursuant to Sections 12101 and 12102 of the Public Contract Code or Division 25.2 (commencing with Section 38070) of the Health and Safety Code, to obtain the most cost-effective electronic data processing, hardware, software services, testing equipment, testing services, and followup contracts.

(2) The expenditure of funds from the Genetic Disease Testing Fund for these purposes shall not be subject to Section 12113.5 of, and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of, the Public Contract Code. The department shall provide the Department of Finance with documentation that equipment and services have been obtained at the lowest cost consistent with technical requirements for a comprehensive high-quality program.

(d) Nothing in this section shall be construed to impose a new mandated benefit on health care service plans and health insurers.



SEC. 16. Section 125190 is added to the Health and Safety Code, to read:

125190. Notwithstanding any other provision of law, the department is considered to be the purchaser, but not the dispenser or distributor, of blood factor products under the Genetically Handicapped Person's Program. The department may receive manufacturers' discounts, rebates, or refunds based on the quantities purchased under the Genetically Handicapped Person's Program. The discounts, rebates, or refunds received pursuant to this section shall be separate from any agreements for discounts, rebates, or refunds negotiated pursuant to Section 14105.3 of the Welfare and Institutions Code or any other program.

SEC. 17. Section 127280.1 is added to the Health and Safety Code, to read:

127280.1. Notwithstanding any other provision of law, up to two hundred thousand dollars (\$200,000) of the moneys collected pursuant to Section 127280 may be used in the 2002–03 fiscal year by the State Department of Health Services for data collection on, analysis of, and reporting on, maternal and perinatal outcomes, if funds are appropriated in the Budget Act.

SEC. 18. Section 12693.17 of the Insurance Code is amended to read:

12693.17. "Family contribution sponsor" means a person or entity that pays the family contribution on behalf of an applicant for any period of 12 consecutive months and, notwithstanding Section 12693.70, if the sponsor is paying for the initial 12 months of eligibility, the payment for 12 months is made with the application.

SEC. 19. Section 12693.41 of the Insurance Code is amended to read:

12693.41. (a) Upon the effective date of coverage of a child eligible for the program, the board shall arrange for payment of providers who participate in the Child Health and Disability Prevention Program pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, for well-child health assessments, immunizations, and initial treatment provided up to 90 days prior to the effective date of coverage.

(b) The board shall pay only for those services that are eligible for federal financial participation under Section 2105 of Title XXI of the Social Security Act and that are approved in the required state plan under that title, except as specified in Section 12693.76.

(c) (1) Child Health and Disability Prevention Program providers shall submit charges for the services under subdivision (a) on the form or in the format specified by the department for the Child Health and



Disability Prevention Program. Those providers shall be reimbursed at the rates established for these services by the Child Health and Disability Prevention Program once coverage under the program is established.

(2) Those providers shall submit charges for services reimbursable under Medi-Cal on the form or in the format specified by the department for Medi-Cal. Those providers shall be reimbursed at the rates established for these services by Medi-Cal once coverage under Medi-Cal is established.

(d) (1) The board may use the state fiscal intermediary for medicaid to process the payments authorized in subdivision (a).

(2) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of contractual claims processing services by the state fiscal intermediary.

(e) This section shall become inoperative on April 1, 2003, and, as of January 1, 2004, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2004, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 20. Section 12693.41 is added to the Insurance Code, to read:

12693.41. (a) The board shall consult and coordinate with the State Department of Health Services in implementing a preenrollment program into the Healthy Families Program or the Medi-Cal program pursuant to subdivision (b) of Section 14011.7 of the Welfare and Institutions Code. The board shall accept the followup application provided for in Section 14011.7 of the Welfare and Institutions Code as an application for the Healthy Families Program. Preenrollment shall be administered by the State Department of Health Services to provide full-scope benefits pursuant to Medi-Cal program requirements, at no cost to the applicant.

(b) The board may use the state fiscal intermediary for medicaid to process the eligibility determinations and payments required pursuant to Section 14011.7 of the Welfare and Institutions Code.

(c) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of processing services by the state fiscal intermediary.

(d) The board may adopt emergency regulations to implement preenrollment into the Healthy Families Program or the Medi-Cal program pursuant to Section 14011.7 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to,



regulations that implement any changes in rules relating to eligibility, enrollment, and disenrollment in the programs pursuant to Sections 12693.45 and 12693.70. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

(e) This section shall become operative on April 1, 2003.

SEC. 21. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area, the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars (\$7) per child with a maximum required contribution of fourteen dollars (\$14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars (\$9) per child with a maximum required contribution of twenty-seven dollars (\$27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been



designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars (\$4) per child with a maximum required contribution of eight dollars (\$8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars (\$6) per child with a maximum required contribution of eighteen dollars (\$18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

SEC. 22. Section 12693.45 of the Insurance Code is amended to read:

12693.45. (a) After two consecutive months of nonpayment of family contributions by an applicant, and a reasonable written notice period of no less than 30 days is provided to the applicant, subscribers or purchasing credit members may be disenrolled for an applicant's failure to pay family contributions. The board may impose or contract for collection actions to collect unpaid family contributions.

(b) Subject to any additional requirements of federal law, disenrollments shall be effective at the end of the second consecutive month of nonpayment.

SEC. 23. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:



(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(B) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 250 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) If the applicant is applying for the purchasing pool, and does not have a family contribution sponsor the applicant shall pay the first month's family contribution and agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.



(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

SEC. 24. Section 12693.981 of the Insurance Code is amended to read:

12693.981. (a) (1) The Healthy Families-to-Medi-Cal Bridge Benefits Program is hereby established to provide any person enrolled for coverage under this part who meets the criteria set forth in subdivision (b) with a two calendar-month period of health care benefits in order to provide the person with an opportunity to apply for Medi-Cal.

(2) The Healthy Families-to-Medi-Cal Bridge Benefits Program shall be administered by the board.

(b) (1) Any person who meets all of the following requirements shall be eligible for two additional calendar months of Healthy Families benefits:

(A) He or she has been receiving, but is no longer eligible for, benefits under the program.

(B) He or she appears to be income eligible for full-scope Medi-Cal benefits without a share of cost.

(2) The two additional calendar months of benefits under this chapter shall begin on the first day of the month following the last day of the person's eligibility for benefits under the program.

(c) The two-calendar-month period of Healthy Families benefits provided under this chapter shall be identical to the scope of benefits that the person was receiving under the program.

(d) Nothing in this section shall be construed to provide Healthy Families benefits for more than a two calendar-month period under any circumstances, including the failure to apply for benefits under the Medi-Cal program or the failure to be made aware of the availability of the Medi-Cal program unless the circumstances described in subdivision (b) reoccur.

(e) This section shall become inoperative if an unappealable court decision or judgment determines that any of the following apply:

(1) The provisions of this section are unconstitutional under the United States Constitution or the California Constitution.

(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the federal Social Security Act.

(3) The provisions of this section require that the health care benefits provided pursuant to this section are required to be furnished for more than two calendar months.

SEC. 25. Section 4094.2 of the Welfare and Institutions Code is amended to read:

4094.2. (a) For the purpose of establishing payment rates for community treatment facility programs, the private nonprofit agencies selected to operate these programs shall prepare a budget that covers the total costs of providing residential care and supervision and mental health services for their proposed programs. These costs shall include categories that are allowable under California's Foster Care program and existing programs for mental health services. They shall not include educational, nonmental health medical, and dental costs.

(b) Each agency operating a community treatment facility program shall negotiate a final budget with the local mental health department in the county in which its facility is located (the host county) and other local agencies as appropriate. This budget agreement shall specify the types and level of care and services to be provided by the community treatment facility program and a payment rate that fully covers the costs included in the negotiated budget. All counties that place children in a community treatment facility program shall make payments using the budget agreement negotiated by the community treatment facility provider and the host county.

(c) A foster care rate shall be established for each community treatment facility program by the State Department of Social Services. These rates shall be established using the existing foster care ratesetting system for group homes, with modifications designed as necessary. It is anticipated that all community treatment facility programs will offer the level of care and services required to receive the highest foster care rate provided for under the current group home ratesetting system.

(d) For the 2001–02 fiscal year and the 2002–03 fiscal year, community treatment facility programs shall also be paid a community treatment facility supplemental rate of up to two thousand five hundred dollars (\$2,500) per child per month on behalf of children eligible under the foster care program and children placed out of home pursuant to an individualized education program developed under Section 7572.5 of the Government Code. Subject to the availability of funds, the supplemental rate shall be shared by the state and the counties. Counties shall be responsible for paying a county share of cost equal to 60 percent of the community treatment rate for children placed by counties in community treatment facilities and the state shall be responsible for 40 percent of the community treatment facility supplemental rate. The community treatment facility supplemental rate is intended to supplement, and not to supplant, the payments for which children placed in community treatment facilities are eligible to receive under the foster care program and the existing programs for mental health services.

(e) For initial ratesetting purposes for community treatment facility funding, the cost of mental health services shall be determined by



deducting the foster care rate and the community treatment facility supplemental rate from the total allowable cost of the community treatment facility program. Payments to certified providers for mental health services shall be based on eligible services provided to children who are Medi-Cal beneficiaries, up to the statewide maximum allowances for these services.

(f) Although there is statutory authorization for up to 400 community treatment facility beds statewide, it is anticipated that there will be a phased-in implementation of community treatment facilities, and that the average monthly community treatment facility caseload during the 2001–02 fiscal year will be approximately 100 and during the 2002–03 fiscal year will be approximately 140.

(g) The department shall provide the community treatment facility supplemental rates to the counties for advanced payment to the community treatment facility providers in the same manner as the regular foster care payment and within the same required payment time limits.

(h) In order to facilitate a study of the costs of community treatment facilities, licensed community treatment facilities shall provide all documents regarding facility operations, treatment, and placements requested by the department.

(i) It is the intent of the Legislature that the department and the State Department of Social Services work to maximize federal financial participation in funding for children placed in community treatment facilities through funds available pursuant to Titles IV-E and XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 670 and following and Sec. 1396 and following) and other appropriate federal programs.

(j) The department and the State Department of Social Services may adopt emergency regulations necessary to implement joint protocols for the oversight of community treatment facilities, to modify existing licensing regulations governing reporting requirements and other procedural and administrative mandates to take into account the seriousness and frequency of behaviors that are likely to be exhibited by the seriously emotionally disturbed children placed in community treatment facility programs, to modify the existing foster care ratesetting regulations, and to pay the community treatment facility supplemental rate. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 180 days unless the adopting agency complies with all the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of



the Government Code, as required by subdivision (e) of Section 11346.1 of the Government Code.

SEC. 26. Section 4380 of the Welfare and Institutions Code is amended to read:

4380. The Legislature authorizes the director, in consultation with the Secretary of Child Development and Education and the Superintendent of Public Instruction, to award matching grants to local educational agencies to pay the state share of the costs of providing programs that provide school-based early mental health intervention and prevention services to eligible pupils at schoolsites of eligible pupils, as follows:

(a) The director shall award matching grants pursuant to this chapter to local educational agencies throughout the state.

(b) Matching grants awarded under this part shall be awarded for a period of not more than three years and no single schoolsite shall be awarded more than one grant, except for a schoolsite that received a grant prior to July 1, 1992.

(c) The director shall pay to each local educational agency having an application approved pursuant to requirements in this part the state share of the cost of the activities described in the application.

(d) Commencing July 1, 1993, the state share of matching grants shall be a maximum of 50 percent in each of the three years.

(e) Commencing July 1, 1993, the local share of matching grants shall be at least 50 percent, from a combination of school district and cooperating entity funds.

(f) The local share of the matching grant may be in cash or payment in-kind.

(g) Priority shall be given to those applicants that demonstrate the following:

(1) The local educational agency will serve the greatest number of eligible pupils from low-income families.

(2) The local educational agency will provide a strong parental involvement component.

(3) The local educational agency will provide supportive services with one or more cooperating entities.

(4) The local educational agency will provide services at a low cost per child served in the project.

(5) The local educational agency will provide programs and services that are based on adoption or modification, or both, of existing programs that have been shown to be effective. No more than 20 percent of the grants awarded by the director may be utilized for new models.



(6) The local educational agency will provide services to children who are in out-of-home placement or who are at risk of being in out-of-home placement.

(h) Eligible supportive services may include the following:

(1) Individual and group intervention and prevention services.

(2) Parent involvement through conferences or training, or both.

(3) Teacher and staff conferences and training related to meeting project goals.

(4) Referral to outside resources when eligible pupils require additional services.

(5) Use of paraprofessional staff, who are trained and supervised by credentialed school psychologists, school counselors, or school social workers, to meet with pupils on a short-term weekly basis, in a one-on-one setting as in the Primary Intervention Program established pursuant to Chapter 4 (commencing with Section 4343) of Part 3. A minimum of 80 percent of the grants awarded by the director shall include the basic components of the Primary Intervention Program.

(6) Any other service or activity that will improve the mental health of eligible pupils.

Prior to participation by an eligible pupil in either individual or group services, consent of a parent or guardian shall be obtained.

(i) Each local educational agency seeking a grant under this chapter shall submit an application to the director at the time, in a manner, and accompanied by any information the director may reasonably require.

(j) Each matching grant application submitted shall include all of the following:

(1) Documentation of need for the school-based early mental health intervention and prevention services.

(2) A description of the school-based early mental health intervention and prevention services expected to be provided at the schoolsite.

(3) A statement of program goals.

(4) A list of cooperating entities that will participate in the provision of services. A letter from each cooperating entity confirming its participation in the provision of services shall be included with the list. At least one letter shall be from a cooperating entity confirming that it will agree to screen referrals of low-income children the program has determined may be in need of mental health treatment services and that, if the cooperating entity determines that the child is in need of those services and if the cooperating entity determines that according to its priority process the child is eligible to be served by it, the cooperating entity will agree to provide those mental health treatment services.

(5) A detailed budget and budget narrative.



(6) A description of the proposed plan for parent involvement in the program.

(7) A description of the population anticipated to be served, including number of pupils to be served and socioeconomic indicators of sites to receive funds.

(8) A description of the matching funds from a combination of local education agencies and cooperating entities.

(9) A plan describing how the proposed school-based early mental health intervention and prevention services program will be continued after the matching grant has expired.

(10) Assurance that grants would supplement and not supplant existing local resources provided for early mental health intervention and prevention services.

(11) A description of an evaluation plan that includes quantitative and qualitative measures of school and pupil characteristics, and a comparison of children's adjustment to school.

(k) Matching grants awarded pursuant to this article may be used for salaries of staff responsible for implementing the school-based early mental health intervention and prevention services program, equipment and supplies, training, and insurance.

(l) Salaries of administrative staff and other administrative costs associated with providing services shall be limited to 5 percent of the state share of assistance provided under this section.

(m) No more than 10 percent of each matching grant awarded pursuant to this article may be used for matching grant evaluation.

(n) No more than 10 percent of the moneys allocated to the director pursuant to this chapter may be utilized for program administration and evaluation.

Program administration shall include both state staff and field staff who are familiar with and have successfully implemented school-based early mental health intervention and prevention services. Field staff may be contracted with by local school districts or community mental health programs. Field staff shall provide support in the timely and effective implementation of school-based early mental health intervention and prevention services. Reviews of each project shall be conducted at least once during the first year of funding.

(o) Subject to the approval of the director, at the end of the fiscal year, a school district may apply unexpended funds to the budget for the subsequent funding year.

(p) Contracts for the program and administration, or ancillary services in support of the program, shall be exempt from the requirements of the Public Contract Code and the State Administrative Manual, and from approval by the Department of General Services.



SEC. 27. Section 4418.2 is added to the Welfare and Institutions Code, to read:

4418.2. The department shall support, utilizing regional resource development projects, the activities specified in Sections 4418.25, 4418.3, and 4418.7.

SEC. 28. Section 4418.25 is added to the Welfare and Institutions Code, to read:

4418.25. (a) The department shall establish policies and procedures for the development of an annual community placement plan by regional centers. The community placement plan shall be based upon an individual program plan process as referred to in subdivision (a) of Section 4418.3 and shall be linked to the development of the annual state budget. The department's policies shall address statewide priorities, plan requirements, and the statutory roles of regional centers, developmental centers, and regional resource development projects in the process of assessing consumers for community living and in the development of community resources.

(b) The community placement plan shall provide for dedicated funding for comprehensive assessments of selected developmental center residents, for identified costs of moving selected individuals from developmental centers to the community, and for deflection of selected individuals from developmental center admission. The plans shall, where appropriate, include budget requests for regional center operations, assessments, resource development, and ongoing placement costs. These budget requests are intended to provide supplemental funding to regional centers. The plan is not intended to limit the department's or regional centers' responsibility to otherwise conduct assessments and individualized program planning, and to provide needed services and supports in the least restrictive, most integrated setting in accord with the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(c) The department shall review, negotiate, and approve regional center community placement plans for feasibility and reasonableness, including recognition of each regional centers' current developmental center population and their corresponding placement level, as well as each regional centers' need to develop new and innovative service models. The department shall hold regional centers accountable for the development and implementation of their approved plans. The regional centers shall report, as required by the department, on the outcomes of their plans. The department shall make aggregate performance data for each regional center available, upon request, as well as data on admissions to, and placements from, each developmental center.



(d) Funds allocated by the department to a regional center for a community placement plan developed under this section shall be controlled through the regional center contract to ensure that the funds are expended for the purposes allocated. Funds allocated for community placement plans that are not used for that purpose may be transferred to Item 4300-003-0001 for expenditure in the state developmental centers if their population exceeds the budgeted level. Any unspent funds shall revert to the General Fund.

SEC. 29. Section 4418.3 of the Welfare and Institutions Code is amended to read:

4418.3. (a) It is the intent of the Legislature to ensure that the transition process from a developmental center to a community living arrangement is based upon the individual's needs, developed through the individual program plan process, and ensures that needed services and supports will be in place at the time the individual moves. It is further the intent of the Legislature that regional centers, developmental centers, and regional resource development projects coordinate with each other for the benefit of their activities in assessment, in the development of individual program plans, and in planning, transition, and deflection, and for the benefit of consumers.

(b) As individuals are identified for possible movement to the community, an individual planning meeting shall be initiated by the developmental center, which shall notify the planning team, pursuant to subdivision (j) of Section 4512, and the regional resource development project of the meeting. The regional resource development project shall make services available to the developmental center and the regional center, including, but not limited to, consultations with the planning teams and the identification of services and supports necessary for the consumer to succeed in community living.

(c) The development of the individual program plan shall be consistent with Sections 4646 and 4646.5. For the purpose of this section, the planning team shall include developmental center staff knowledgeable about the service and support needs of the consumer.

(d) Regional resource development project services may include providing information in an understandable form to consumers and, where appropriate, their families, conservators, legal guardians, or authorized representatives, that will assist them in making decisions about community living and services and supports. This information may include affording the consumer the opportunity to visit a variety of community living arrangements that could meet his or her needs. If the visits are not feasible, as determined by the planning team, a family member or other representative of the consumer may conduct the visits. Regional resource development projects may be requested to facilitate



these visits. The availability of this service shall be made known by the planning team to consumers and, where appropriate, their families, conservators, legal guardians, or authorized representative.

(e) Once the individual program plan is completed and providers of services and supports are identified and agreed to, pursuant to subdivision (b) of Section 4646.5, and no less than 15 days prior to the move, unless otherwise ordered by a court, a transition conference, which may be facilitated by a regional resource development project, shall be held. Participants in the transition conference shall include, but not be limited to, the consumer, where appropriate the consumer's parents, legal guardian, conservator, or authorized representative, a regional center representative, a developmental center representative, and a representative of each provider of primary services and supports identified in the individual program plan. This meeting may take place in the catchment area to which the consumer is moving. If necessary, conferees may participate by telephone or video conference. The purpose of this conference shall be to ensure a smooth transition from the developmental center to the community.

(f) The department, through the appropriate regional resource development project, shall provide, in cooperation with regional centers and developmental centers, followup services to help ensure a smooth transition to the community. Followup services shall include, but shall not be limited to, all of the following:

(1) Regularly scheduled as well as on an as-needed basis, contacts and visits with consumers and service providers during the 12 months following the consumers movement date.

(2) Participation in the development of an individual program plan in accordance with Sections 4646 and 4646.5.

(3) Identification of issues that need resolution.

(4) Arrangement for the provision of developmental center services, including, but not limited to, medication review, crisis services, and behavioral consultation.

(g) To ascertain that the individual program plan is being implemented, that planned services are being provided, and that the consumer and, where appropriate the consumer's parents, legal guardian, or conservator, are satisfied with the community living arrangement, the regional center shall schedule face-to-face reviews no less than once every 30 days for the first 90 days. Following the first 90 days, and following notification to the department, the regional center may conduct these reviews less often as specified in the individual program plan.

(h) The regional center and the regional resource development project shall coordinate their followup reviews required pursuant to



subdivisions (f) and (g) and shall share with each other information obtained during the course of the followup visits.

SEC. 30. Section 4418.7 of the Welfare and Institutions Code is amended to read:

4418.7. (a) If the regional center determines, or is informed by the consumer's parents, legal guardian, conservator, or authorized representative that the community placement of a consumer is at risk of failing, and that admittance to a state developmental center is a likelihood, the regional center shall immediately notify the appropriate regional resource development project, the consumer, and the consumer's parents, legal guardian, or conservator.

(b) In these cases, the regional resource development project shall immediately arrange for an assessment of the situation, including, visiting the consumer, if appropriate, determining barriers to successful integration, and recommending the most appropriate means necessary to assist the consumer to remain in the community. If, based on the assessment, the regional resource development project determines that additional or different services and supports are necessary, the department shall ensure that the regional center provides those services and supports on an emergency basis. An individual program plan meeting, including the regional resource development project's representative, shall be convened as soon as possible to review the emergency services and supports and determine the consumer's ongoing needs for services and supports. The regional resource development project shall follow up with the regional center as to the success of the recommended interventions until the consumer's living arrangement is stable.

(c) If the regional resource development project, in consultation with the regional center, the consumer, and the consumer's parents, legal guardian, or conservator, when appropriate, determines that admittance to a state developmental center is necessary to prevent a substantial risk to the individual's health and safety, the regional resource development project shall immediately facilitate that admission.

(d) The department shall collect data on the outcomes of efforts to assist at-risk consumers to remain in the community. The department shall make aggregate data on the implementation of the requirements of this section available, upon request.

SEC. 30.5. Section 4631.5 is added to the Welfare and Institutions Code, to read:

4631.5. (a) The Legislature finds and declares both of the following:



(1) The state is facing an unprecedented fiscal crisis that will require an unallocated reduction in the 2002–03 fiscal year for regional centers' purchase of service budgets of fifty-two million dollars (\$52,000,000).

(2) Even when the state faces an unprecedented fiscal crisis, the services and supports set forth in the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)) shall continue to be provided to individuals with developmental disabilities in accordance with state and federal statutes, regulations, and case law, including *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.

(b) It is the intent of the Legislature that actions taken pursuant to this section shall not eliminate an individual's eligibility, adversely affect an individual's health and safety, or interfere with an individual's rights as described in Section 4502.

(c) In order to ensure that services to eligible consumers are available throughout the fiscal year, regional centers shall administer their contracts within the level of funding appropriated by the annual Budget Act.

(d) Within 30 days of the enactment of the annual Budget Act, and after consultation with stakeholder organizations, the department shall determine the amount of unallocated reduction that each regional center shall make in its purchase-of-service budget and shall provide each regional center with guidelines, technical assistance, and a variety of options for reducing operations and purchase of service costs.

(e) Within 60 days of the enactment of the annual Budget Act, each regional center shall develop and submit a plan to the department describing in detail how it intends to absorb the unallocated reduction and achieve savings necessary to provide services to eligible consumers throughout the fiscal year within the limitations of the funds allocated. Prior to adopting the plan, each regional center shall hold a public hearing in order to receive comment on the plan. The regional center shall provide notice to the community at least 10 days in advance of the public hearing. The regional center shall summarize and respond to the public testimony in its plan.

(f) A regional center shall implement components of its plans upon approval of the department. Within 30 days of receipt of the plan, the department shall review and approve, or require modification of, portions of the regional center's plan.

(g) This section shall become inoperative on July 1, 2004, and, as of January 1, 2005, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2005, deletes or extends the dates on which it becomes inoperative and is repealed.



SEC. 31. Section 4640.6 of the Welfare and Institutions Code is amended to read:

4640.6. (a) In approving regional center contracts, the department shall ensure that regional center staffing patterns demonstrate that direct service coordination are the highest priority.

(b) Contracts between the department and regional centers shall require that regional centers implement an emergency response system that ensures that a regional center staff person will respond to a consumer, or individual acting on behalf of a consumer, within two hours of the time an emergency call is placed. This emergency response system shall be operational 24 hours per day, 365 days per year.

(c) Contracts between the department and regional centers shall require regional centers to have service coordinator-to-consumer ratios, as follows:

(1) An average service coordinator-to-consumer ratio of 1 to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.

(2) An average service coordinator-to-consumer ratio of 1 to 45 for all consumers who have moved from a developmental center to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 59 consumers for more than 60 days.

(d) For purposes of this section, “service coordinator” means a regional center employee whose primary responsibility includes preparing, implementing, and monitoring consumers’ individual program plans, securing and coordinating consumer services and supports, and providing placement and monitoring activities.

(e) In order to ensure that caseload ratios are maintained pursuant to this section, each regional center shall provide service coordinator caseload data to the department in September and March of each fiscal year, commencing in the 1999–2000 fiscal year. The data shall be submitted in a format prescribed by the department. Within 30 days of receipt of data submitted pursuant to this subdivision, the department shall make a summary of the data available to the public upon request. The department shall verify the accuracy of the data when conducting regional center fiscal audits. Data submitted by regional centers pursuant to this subdivision shall:

(1) Only include data on service coordinator positions as defined in subdivision (d). Regional centers shall identify the number of positions that perform service coordinator duties on less than a full-time basis.



Staffing ratios reported pursuant to this subdivision shall reflect the appropriate proportionality of these staff to consumers served.

(2) Be reported separately for service coordinators whose caseload primarily includes any of the following:

(A) Consumers who are three years of age and older and who have not moved from the developmental center to the community since April 14, 1993.

(B) Consumers who have moved from a developmental center to the community since April 14, 1993.

(C) Consumers who are younger than three years of age.

(3) Not include positions that are vacant for more than 60 days.

(f) The department shall provide technical assistance and require a plan of correction for any regional center that, for two consecutive reporting periods, fails to maintain service coordinator caseload ratios required by this section or otherwise demonstrates an inability to maintain appropriate staffing patterns pursuant to this section. Plans of correction shall be developed following input from the local area board, local organizations representing consumers, family members, regional center employees, including recognized labor organizations, and service providers, and other interested parties.

(g) Contracts between the department and regional center shall require the regional center to have, or contract for, all of the following areas:

(1) Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.

(2) Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.

(3) Family support expertise to assist the regional center in maximizing the effectiveness of support and services provided to families.

(4) Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supportive living arrangements.

(5) Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.

(6) Quality assurance expertise, to assist the regional center to provide the necessary coordination and cooperation with the area board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.



(7) Each regional center shall employ at least one consumer advocate who is a person with developmental disabilities.

(8) Other staffing arrangements related to the delivery of services that the department determines are necessary to ensure maximum cost-effectiveness and to ensure that the service needs of consumers and families are met.

(h) Any regional center proposing a staffing arrangement that substantially deviates from the requirements of this section shall request a waiver from the department. Prior to granting a waiver, the department shall require a detailed staffing proposal, including, but not limited to, how the proposed staffing arrangement will benefit consumers and families served, and shall demonstrate clear and convincing support for the proposed staffing arrangement from constituencies served and impacted, that include, but are not limited to, consumers, families, providers, advocates, and recognized labor organizations. In addition, the regional center shall submit to the department any written opposition to the proposal from organizations or individuals, including, but not limited to, consumers, families, providers, and advocates, including recognized labor organizations. The department may grant waivers to regional centers that sufficiently demonstrate that the proposed staffing arrangement is in the best interest of consumers and families served, complies with the requirements of this chapter, and does not violate any contractual requirements. A waiver shall be approved by the department for up to 12 months, at which time a regional center may submit a new request pursuant to this subdivision.

(i) The requirements of subdivisions (c), (f), and (h) shall not apply when a regional center is required to develop an expenditure plan pursuant to Section 4791, and when the expenditure plan addresses the specific impact of the budget reduction on staffing requirements and the expenditure plan is approved by the department.

(j) (1) Any contract between the department and a regional center entered into on and after January 1, 2003, shall require that all employment contracts entered into with regional center staff or contractors be available to the public for review, upon request. For purposes of this subdivision, an employment contract or portion thereof may not be deemed confidential nor unavailable for public review.

(2) Notwithstanding paragraph (1), the social security number of the contracting party may not be disclosed.

(3) The term of the employment contract between the regional center and an employee or contractor shall not exceed the term of the state's contract with the regional center.

SEC. 32. Section 4643 of the Welfare and Institutions Code is amended to read:



4643. (a) If assessment is needed, prior to July 1, 2003, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b). On and after July 1, 2003, the assessment shall be performed within 60 days following intake and if unusual circumstances prevent the completion of assessment within 60 days following intake, this assessment period may be extended by one 30-day period with the advance written approval of the department.

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

SEC. 33. Section 4646.5 of the Welfare and Institutions Code is amended to read:

4646.5. (a) The planning process for the individual program plan described in Section 4646 shall include all of the following:

(1) Gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the person with developmental disabilities. For children with developmental disabilities, this process should include a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments shall be conducted by qualified individuals and performed in natural environments whenever possible. Information shall be taken from the consumer, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The assessment process shall reflect awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

(2) A statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities, and a statement of specific, time-limited objectives for implementing the person's goals and addressing his or her needs. These objectives shall be



stated in terms that allow measurement of progress or monitoring of service delivery. These goals and objectives should maximize opportunities for the consumer to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over his or her life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals.

(3) When developing individual program plans for children, regional centers shall be guided by the principles, process, and services and support parameters set forth in Section 4685.

(4) A schedule of the type and amount of services and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the individual program plan goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. The plan shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services.

(5) When agreed to by the consumer, the parents or legally appointed guardian of a minor consumer, or the legally appointed conservator of an adult consumer or the authorized representative, including those appointed pursuant to Section 4590 and subdivision (e) of Section 4705, a review of the general health status of the adult or child including a medical, dental, and mental health needs shall be conducted. This review shall include a discussion of current medications, any observed side effects, and the date of last review of the medication. Service providers shall cooperate with the planning team to provide any information necessary to complete the health status review. If any concerns are noted during the review, referrals shall be made to regional center clinicians or to the consumer's physician, as appropriate. Documentation of health status and referrals shall be made in the consumer's record by the service coordinator.

(6) A schedule of regular periodic review and reevaluation to ascertain that planned services have been provided, that objectives have been fulfilled within the times specified, and that consumers and families are satisfied with the individual program plan and its implementation.

(b) For all active cases, individual program plans shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years. If the consumer or, where appropriate, the consumer's parents, legal guardian,



or conservator requests an individual program plan review, the individual program shall be reviewed within 30 days after the request is submitted.

(c) (1) The department, with the participation of representatives of a statewide consumer organization, the Association of Regional Center Agencies, an organized labor organization representing service coordination staff, and the Organization of Area Boards shall prepare training material and a standard format and instructions for the preparation of individual program plans, which embodies an approach centered on the person and family.

(2) Each regional center shall use the training materials and format prepared by the department pursuant to paragraph (1).

(3) The department shall biennially review a random sample of individual program plans at each regional center to assure that these plans are being developed and modified in compliance with Section 4646 and this section.

SEC. 34. Section 4781.5 is added to the Welfare and Institutions Code, to read:

4781.5. For the 2002–03 fiscal year only, a regional center may not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer’s health or safety or because of other extraordinary circumstances, and the department has granted prior written authorization for the expenditure. This provision shall not apply to any of the following:

(a) The purchase of services funds allocated as part of the department’s community placement plan process.

(b) Expenditures for the startup of new programs made pursuant to a contract entered into before July 1, 2002.

SEC. 34.5. Section 4847 of the Welfare and Institutions Code is repealed.

SEC. 35. Section 5600.8 of the Welfare and Institutions Code is amended to read:

5600.8. (a) The department may allocate the funds appropriated in Schedule (2) of Item 4440-101-0001 of the annual Budget Act, to county mental health programs that meet programmatic goals and model adult system of care programs to the satisfaction of the department. The department shall audit and monitor the use of these funds to ensure they are used solely in support of Adult System of Care programming. If county programs receiving adult system of care funding do not comply with program and audit requirements determined by the department, funding shall be redistributed to other counties to implement, expand, or model adult systems of care.



(b) The department may allocate the funds appropriated in Schedule (3) of Item 4440-101-0001 of the annual Budget Act, to county mental health programs for Children's System of Care programming. These funds shall be utilized by counties only in support of a mental health system serving seriously emotionally disturbed children, in accordance with the principles and program requirements associated with the system of care model, as set forth in Part 4 (commencing with Section 5850). The department shall audit and monitor the use of these funds to ensure they are used solely in support of the Children's System of Care program. If county programs receiving children's system of care funding do not comply with program and audit requirements determined by the department, funds shall be redistributed to other counties to implement, expand, or model children's system of care programming.

SEC. 36. Section 5767 is added to the Welfare and Institutions Code, to read:

5767. The department, in consultation with a statewide organization representing county mental health services, shall strengthen and ensure statewide application of managed care principles, building on existing county systems, to manage the Early Periodic Screening Diagnosis and Treatment Program benefit while ensuring access to eligible Medi-Cal recipients.

SEC. 37. Section 5869 of the Welfare and Institutions Code is amended to read:

5869. The department shall provide participating counties with all of the following:

(a) Applications for funding guidelines and format, and coordination and oversight of the selection process as described in Article 4 (commencing with Section 5857).

(b) Contracts with each state funded county specifying the approved budget, performance outcomes, and a scope of work plan for each year of participation in the children's system of care program.

(c) Technical assistance related to system evaluation.

SEC. 38. Section 5881 of the Welfare and Institutions Code is amended to read:

5881. (a) Evaluation shall be conducted by both participating county evaluation staff and, subject to the availability of funds, by the department.

(b) Evaluation at both levels shall do all of the following:

(1) Ensure that county level systems of care are serving the targeted population.

(2) Ensure that the timely performance data related to client outcome and cost avoidance is collected, analyzed, and reported.



(3) Ensure that system of care components are implemented as intended.

(4) Provide information documenting needs for future planning.

SEC. 39. Section 5882 of the Welfare and Institutions Code is amended to read:

5882. (a) Participating counties shall assign sufficient resources to performance evaluation to enable the county to fulfill all evaluation responsibilities specified in the contract with the department.

(b) Counties shall cooperate with the department regarding the development of uniform measures of performance.

SEC. 40. Section 5883 of the Welfare and Institutions Code is amended to read:

5883. (a) The department shall facilitate improved access to relevant client and financial data from all state agencies, including, but not limited to, the State Department of Social Services, the State Department of Education, the State Department of Health Services, the State Department of Mental Health, the Department of the Youth Authority, and the Department of Finance.

(b) The State Department of Mental Health shall expand the funding allocated to the contract for independent evaluation, as necessary to accommodate the increase in workload created by the addition of new sites.

(c) Subject to the availability of funds, the department shall do all of the following:

(1) Develop uniform data collection and reporting measures applicable to all participating counties.

(2) Collect, analyze, and report performance outcome data for participating counties as a group in comparison to state averages.

(3) Offer technical assistance to participating counties related to data collection, analysis, and reporting.

SEC. 41. Section 14000.03 is added to the Welfare and Institutions Code, to read:

14000.03. (a) The Legislature finds and declares that Section 1396a(a)(11)(A) of Title 42 of the United States Code provides that California's state plan for medical assistance under the Medicaid program must "provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan."

(b) In furtherance of Section 1396a(a)(11)(A) of Title 42 of the United States Code and Section 7560 of the Government Code, it is the intent of the Legislature to maximize the amount of federal and state funds



continually available under agreements identified in Section 1396a(a)(11)(A) of Title 42 of the United States Code and entered into by the State Department of Health Services by making later-appropriated and budgeted funds immediately encumbered and available for expenditure under agreements by operation of law.

(c) Notwithstanding any other provision of law, upon additional funds being appropriated and budgeted for the support of the services identified within the scope of work of an agreement of the type identified in Section 1396a (a)(11)(A) of Title 42 of the United States Code and previously entered into by the State Department of Health Services, the amount of the encumbrance in such an agreement shall be amended, by operation of law, to reflect the newly appropriated and budgeted funds.

(d) Notwithstanding any other provision of law, once an agreement of the type identified in Section 1396a (a)(11)(A) of Title 42 of the United States Code is entered into by the State Department of Health Services, the agreement shall continue in effect indefinitely and need not be amended unless the State Department of Health Services changes the scope of work to be provided under the agreement.

SEC. 42. Section 14000.5 is added to the Welfare and Institutions Code, to read:

14000.5. On a regional pilot project basis, to the extent authorized by law, the director may enter into contracts with one or more nonprofit organizations to perform the functions of the department's Office of the Ombudsman. These activities may include outreach, community education and training about health care consumer rights and responsibilities, including the production and distribution of consumer-oriented material, individual consumer assistance, including counseling, advice, assistance, education, advocacy, and referral as appropriate, establishing and operating a database to analyze the nature of the inquiries and requests for assistance, and training of department or county staff. These services may be made available to any person who may be eligible for or is receiving benefits under this chapter. Funds appropriated in the annual Budget Act for the support of the Office of the Ombudsman may be allocated for this purpose.

SEC. 43. Section 14005.41 of the Welfare and Institutions Code is amended to read:

14005.41. (a) Notwithstanding any other provision of law, the department shall deem to have met the income documentation requirements for participation in the Medi-Cal program, without a share of cost, any child who is less than six years of age and who has been determined to be eligible for free meals through a federally funded program using the National School Lunch application provided for



pursuant to Chapter 13 (commencing with Section 1751) of Title 42 of the United States Code.

(b) Notwithstanding any other provision of law, with regard to any child who is enrolled in and attending public school in the State of California, the department shall accept documentation of enrollment for free meals under the National School Lunch Program as sufficient documentation of California residency for that child for the purposes of the Medi-Cal program.

(c) (1) (A) Effective July 1, 2003, notwithstanding any other provision of law, each county shall participate in a statewide pilot project to determine Medi-Cal program eligibility for any child under six years of age and currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). Counties shall notify the parent or guardian of the results of the eligibility determination.

(B) Effective July 1, 2003, notwithstanding any other provision of law, each county shall participate in a statewide pilot project to use the procedure described in this subdivision to determine Medi-Cal eligibility without a share of cost, and, if eligible, shall enroll in the Medi-Cal program, any child six years of age or older currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program, upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). If the county determines from the supplemented application described in subdivision (i) that the child meets the eligibility requirements for participation in the Medi-Cal program, the county shall notify the parent or guardian that the child has been found eligible for the Medi-Cal program. If the county is unable to determine from the information on the application as described in subdivision (i) whether the child is eligible, the county shall contact the family to seek any additional information regarding income, household composition, or deductions that the department, in consultation with the county welfare departments, may determine to be necessary to complete the Medi-Cal application. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall notify the parent or guardian of the determination and shall send the parent or guardian an application for the Healthy Families Program.

(2) Each county shall ask the parent or guardian of each child identified in subparagraph (A) of paragraph (1) and the parent or



guardian of each child whom the county determines to meet the income eligibility requirements for participation in the Medi-Cal program under subparagraph (B) of paragraph (1) to provide additional documentation as required by current law necessary for retention of eligibility in the Medi-Cal program. If a parent or guardian does not provide the documentation required for retention of full-scope Medi-Cal program eligibility, the county shall continue the child's enrollment in the Medi-Cal program, but only for the limited scope of Medi-Cal program benefits as described in Section 14007.5.

(d) Nothing in this section shall be construed as preventing the department from verifying eligibility through the Income Eligibility Verification System match mandated by Section 1137 of the federal Social Security Act (42 U.S.C. Sec. 1320b-7) or from requesting additional information or documentation required by federal law.

(e) Each county shall include its cost of implementing this section in its annual Medi-Cal administrative budget requests submitted to the department.

(f) For purposes of this section, the Medi-Cal program application date shall be the date on which the school lunch application information is received by the local agency determining eligibility under the Medi-Cal program.

(g) (1) This section shall be implemented on July 1, 2003, only if, and to the extent that, federal financial participation is available for the services provided and only for the period of time the free National School Lunch Program utilizes a gross income standard at or below 133 percent of the federal poverty level. This section shall be implemented in a manner consistent with any federal approval.

(2) Notwithstanding paragraph (1), if the department determines that one or more state plan amendments are necessary to ensure full federal financial participation in the provisions of this section, the department shall prepare and submit requests for the state plan amendments to the federal government, after which this section shall not be implemented until the later of the date the department receives approval of all necessary state plan amendments, or July 1, 2003.

(h) (1) Notwithstanding subdivision (g), not later than March 1, 2003, the department, in consultation with the State Department of Education and representatives of the school districts, county superintendents of schools, local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement Section 49557.2 of the Education Code and this section.



(2) The policies and procedures required to be developed and distributed pursuant to subdivision (a) shall include, at a minimum, both of the following:

(A) Processes for the school districts, county superintendents of schools, and local agencies that administer the Medi-Cal program to use in forwarding and processing free school lunch application information pursuant to Section 49557.2 of the Education Code, and in following up with the applicants to obtain any necessary documentation required by federal law.

(B) Instructions for implementing the eligibility provisions of this chapter.

(3) The policies and procedures required to be developed pursuant to subdivision (a) shall specify all of the following:

(A) The information on the school lunch application may be used to initiate a Medi-Cal program application only when the applicant has provided his or her consent pursuant to Section 49557.2 of the Education Code.

(B) The date of the Medi-Cal program application shall be the date on which the school lunch application was received by the local agency that determines eligibility under the Medi-Cal program.

(C) The county, in determining eligibility for the Medi-Cal program, shall request additional documentation only as required by federal law, and shall enroll any child whose parent or guardian does not provide the necessary documentation for full-scope benefits under the Medi-Cal program in the Medi-Cal program with limited scope benefits, as described in Section 14007.5.

(i) To the extent federal financial participation is available, and to the extent administratively feasible, the department shall utilize the free National School Lunch Application developed under Section 49557.2 of the Education Code, if supplemented as needed by simplified forms and disclosures, including Medi-Cal rights and responsibility notices and privacy notices, as a Medi-Cal application for children described in this section.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(k) The department shall review the effectiveness of the statewide pilot project and make recommendations regarding appropriate ways to expand the use of the approaches contained in this section.



(l) In order to expedite health coverage for children who have been determined eligible for free meals under the National School Lunch Program, the department, at its discretion, may choose to implement this section in whole or in part by exercising the option described in Section 1396r-1a of Title 42 of the United States Code to allow information provided on the National School Lunch Program application referred to, and supplemented as described, in paragraph (1) of subdivision (a) of Section 49557.2 of the Education Code to serve as a basis for a preliminary eligibility determination by a qualified entity designated by the department.

SEC. 44. Section 14011.6 of the Welfare and Institutions Code is amended to read:

14011.6. (a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920a of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to implement a program for accelerated enrollment of children.

(b) The department shall designate the single point of entry, as defined in subdivision (c), as the qualified entity for determining eligibility under this section.

(c) For purposes of this section, “single point of entry” means the centralized processing entity that accepts and screens applications for benefits under the Medi-Cal Program for the purpose of forwarding them to the appropriate counties.

(d) The department shall implement this section only if, and to the extent that, federal financial participation is available.

(e) The department shall seek federal approval of any state plan amendments necessary to implement this section. When federal approval of the state plan amendment or amendments is received, the department shall commence implementation of this section on the first day of the second month following the month in which federal approval of the state plan amendment or amendments is received, or on July 1, 2002, whichever is later.

(f) Notwithstanding any other provision of law, the department shall implement this section only if, and to the extent that, the federal State Children’s Health Insurance Program waiver described in Section 12693.755 of the Insurance Code is approved by the federal government.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all-county letters. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.



(h) Upon the receipt of an application for a child who has coverage pursuant to the accelerated enrollment program, a county shall determine whether the child is eligible for Medi-Cal benefits. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall report this finding to the Medical Eligibility Data System so that accelerated enrollment coverage benefits are discontinued. The information to be reported shall consist of the minimum data elements necessary to discontinue that coverage for the child. This subdivision shall become operative on July 1, 2002, or the date that the program for accelerated enrollment coverage for children takes effect, whichever is later.

SEC. 45. Section 14011.7 is added to the Welfare and Institutions Code, to read:

14011.7. (a) To the extent allowed under federal law and only if federal financial participation is available, the department shall exercise the option provided in Section 1396r-1a of Title 42 of the United States Code and the Managed Risk Medical Insurance Board shall exercise the option provided in Section 1397gg(e)(1)(D) of Title 42 of the United States Code to implement a program for preenrollment of children into the Medi-Cal program or the Healthy Families Program. Upon the exercise of both of the federal options described in this subdivision, the department shall implement and administer a program of preenrollment of children into the Medi-Cal program or the Healthy Families Program.

(b) Before July 1, 2003, the department shall develop an electronic application to serve as the application for preenrollment into the Medi-Cal program or the Healthy Families Program and to also serve as an application for the Child Health and Disability Prevention (CHDP) program, to the extent allowed under federal law.

(c) (1) The department may designate, as necessary, those CHDP program providers described in paragraphs (1) to (5), inclusive, of subdivision (g) of Section 124030 of the Health and Safety Code as qualified entities who are authorized to determine eligibility for the CHDP program and for preenrollment into either the Medi-Cal program or the Healthy Families Program as authorized under this section.

(2) The CHDP provider shall assist the parent or guardian of the child seeking eligibility for the CHDP program and for preenrollment into the Medi-Cal program or the Healthy Families Program in completing the electronic application.

(d) The electronic application developed pursuant to subdivision (b) may only be filed through the CHDP program when the child is in need of CHDP program services in accordance with the periodicity schedule used by the CHDP program.



(e) (1) The electronic application developed pursuant to subdivision (b) shall request all information necessary for a CHDP provider to make an immediate determination as to whether a child meets the eligibility requirements for CHDP and for preenrollment into either the Medi-Cal program or the Healthy Families Program pursuant to the federal options described in Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United States Code.

(2) (A) If the electronic application indicates that the child is seeking eligibility for either no cost full-scope Medi-Cal benefits or enrollment in the Healthy Families Program, the department shall mail to the child's parent or guardian a followup application for Medi-Cal program eligibility or enrollment in the Healthy Families Program. The parent or guardian of the child shall be advised to complete and submit to the appropriate entity the followup application.

(B) The followup application, at a minimum, shall include all notices and forms necessary for both a Medi-Cal program and a Healthy Families Program eligibility determination under state and federal law, including, but not limited to, any information and documentation that is required for the joint application package described in Section 14011.1.

(C) The date of application for the Medi-Cal program or the Healthy Families Program is the date the completed followup application is submitted with the appropriate entity by the parent or guardian.

(3) Upon making a determination pursuant to paragraph (1) that a child is eligible, the CHDP provider shall inform the child's parent or guardian of both of the following:

(A) That the child has been determined to be eligible for services under the CHDP program and, if applicable, eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program.

(B) That if the child has been determined to be eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the followup application described in paragraph (2) on or before that date.

(4) If the followup application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.

(f) The scope and delivery of benefits provided to a child who is preenrolled for the Healthy Families Program pursuant to this section



shall be identical to the scope and delivery of benefits received by a child who is preenrolled for the Medi-Cal program pursuant to this section.

(g) The department and the Managed Risk Medical Insurance Board shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 U.S.C. 1396 et seq.) and Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.

(h) Upon the implementation of this section, this section shall control in the event of a conflict with any provision of Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code governing the Child Health and Disability Prevention program.

(i) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contract for the Child Health and Disability Prevention Program, including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(k) Notwithstanding subdivision (g), in no event shall this section be implemented before April 1, 2003.

SEC. 46. Section 14011.8 is added to the Welfare and Institutions Code, to read:

14011.8. (a) Benefits provided to an individual pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or



1396r-1b of Title 42 of the United States Code shall end, without the necessity for any further review or determination by the department, on or before the last day of the month following the month in which the preliminary determination was made, unless an application for medical assistance under the state plan is filed on or before that date.

(b) If an application for medical assistance is filed on or before the last day of the month following the month in which the preliminary determination was made, preliminary benefits shall continue until the regular eligibility determination based on the application has been completed. The application shall be treated in all respects as an initial application for benefits and the following shall apply:

(1) In the case of an applicant who is found eligible for medical assistance, benefits shall be granted in an amount and under those conditions, including imposition of a share of cost, as have been found applicable pursuant to the regular eligibility determination.

(2) In the case of all other applicants, provision of preliminary benefits shall end on the day that the regular eligibility determination is made.

(c) Notwithstanding any other provision of law, medical assistance pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall be provided only if and to the extent federal financial participation is available.

SEC. 47. Section 14011.9 is added to the Welfare and Institutions Code, to read:

14011.9. (a) On or before October 1, 2002, the department shall issue instructions to counties via an all-county letter or similar instructions to establish an automated system for tracking the status of applications received by county welfare departments from the centralized processing entity that accepts and screens applications for benefits under the Medi-Cal program for the purpose of forwarding these applications to the appropriate counties. Except for reporting denials of applications on behalf of children enrolled in accelerated Medi-Cal coverage pursuant to subdivision (g) of Section 14011.6, the department shall not institute a process to require county welfare departments to routinely manually report to the Medi-Cal Eligibility Data System (MEDS) regarding the status of applications for Medi-Cal coverage prior to the development of an interface between that county's automated eligibility determination system and the MEDS system for the purposes of implementing this section. It is the intent of the Legislature that the Health Human Services Data Center and the counties complete the automation changes necessary to implement the automated tracking system on or before July 1, 2003.



(b) This section shall be implemented only to the extent that federal financial participation is not jeopardized.

(c) Nothing in this section shall be construed as prohibiting the department from requiring a county to report on the status of an individual application or to manually generate a report on a statistically valid sampling of applications pursuant to federally required monitoring activities.

SEC. 47.5. Section 14019.3 of the Welfare and Institutions Code is amended to read:

14019.3. (a) A beneficiary or any person on behalf of the beneficiary who has paid for health care services otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a return from the provider of any part of the payment that meets all of the following:

(1) Was rendered during any period prior to the receipt of his or her Medi-Cal card, for which the card authorizes payment under Section 14018 or 14019.

(2) Was reimbursed to the provider by the Medi-Cal program, following all audits and appeals to which the provider is entitled.

(3) Is not payable by a third party under contractual or other legal entitlement.

(4) Was not used to satisfy his or her paid or obligated liability for health care services or to establish eligibility.

(b) To the extent permitted by federal law, whether or not a facility actually evicts a beneficiary, a beneficiary who may validly be evicted pursuant to Section 1439.7 of the Health and Safety Code, and who has received and paid for health care services otherwise covered by the Medi-Cal program shall not be entitled to the return from the provider of any part of the payment for which service was rendered during any period prior to the date upon which knowledge is acquired by the licensee of the application of the beneficiary for Medi-Cal or the date of application for Medi-Cal, whichever is later.

(c) Upon presentation of the Medi-Cal card or other proof of eligibility, the provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program.

(d) Notwithstanding subdivision (c), payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full, except that a provider, after making a full refund to the department of any Medi-Cal payments received for services, may recover all provider fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification



insurance program, is obligated to pay the charges for the care provided the beneficiary.

(e) The provider shall return any and all payments made by the beneficiary, or any person on behalf of the beneficiary, other than a third party obligated to pay charges by reason of the beneficiary's other contractual or legal entitlement for Medi-Cal program covered services upon receipt of Medi-Cal payment.

(f) To the extent permitted by federal law, the department shall waive overpayments made to a pharmacy provider that would otherwise be reimbursable to the department for prescription drugs returned to the pharmacy provider from a nursing facility upon discontinuation of the drug therapy or death of the beneficiary.

SEC. 48. Section 14051 of the Welfare and Institutions Code is amended to read:

14051. (a) "Medically needy person" means any of the following:

(1) An aged, blind, or disabled person who meets the definition of aged, blind, or disabled under the Supplemental Security Income Program and whose income and resources are insufficient to provide for the costs of health care or coverage.

(2) A child in foster care for whom public agencies are assuming financial responsibility, in whole or in part, or a person receiving aid under Chapter 2.1 (commencing with Section 16115) of Part 4.

(3) A child who is eligible to receive Medi-Cal benefits pursuant to interstate agreements for adoption assistance and related services and benefits entered into under Chapter 2.6 (commencing with Section 16170) of Part 4, to the extent federal financial participation is available.

(b) "Medically needy family person" means a parent or caretaker relative of a child who meets the deprivation requirements of Aid to Families with Dependent Children or a child under 21 years of age or a pregnant woman of any age with a confirmed pregnancy, exclusive of those persons specified in subdivision (a), whose income and resources are insufficient to provide for the costs of health care or coverage.

SEC. 49. Section 14085.7 of the Welfare and Institutions Code is amended to read:

14085.7. (a) The Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section. Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51



of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (e). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(e) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(f) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this



section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(g) This section shall become inoperative on July 1, 2004, and, as of January 1, 2005, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2005, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 50. Section 14085.8 of the Welfare and Institutions Code is amended to read:

14085.8. (a) The Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section.

(c) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be



allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(2) Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(h) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(i) This section shall become inoperative on July 1, 2004, and, as of January 1, 2005, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2005, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 51. Section 14103.6 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 1005 of the Statutes of 1975, is amended to read:

14103.6. The director, or a carrier acting under regulations adopted by the director, may require that any individual provider shall receive prior authorization before providing services when the director or carrier determines that the provider has been rendering unnecessary services.

At any time the director determines that it is necessary to postpone elective services pursuant to Section 14120, he or she shall require prior authorization for those services determined to be generally elective under the provisions of Section 14103.4, except a service which costs less than one hundred dollars (\$100) or a lower amount determined by the director. This lower amount may be applied generally or for specific services. The director may terminate the requirement for prior



authorization when he or she determines that it is no longer necessary to postpone elective services.

Prior authorization for services provided by persons licensed under the provisions of Chapter 4 (commencing with Section 1600) and Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code shall be determined by consultants licensed under Chapter 4 or Chapter 7 respectively. Prior authorization for all other elective services shall be determined by consultants licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, provided, however, that prior authorization for pharmaceutical services may be determined by persons licensed under the provisions of Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code, and prior authorization for services provided in an inpatient setting may be reviewed and approved, but not denied, by a person licensed under the provisions of Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, working under the supervision of a consultant licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

In no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment.

In carrying out this section, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for staff to accomplish the treatment authorization request reviews and medical case management, including appeals. The fiscal intermediary contract, including any contract amendment, system change pursuant to a change order, and project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, and any policies, procedures, or regulations authorized by those laws.

SEC. 52. Section 14103.6 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 682 of the Statutes of 1985, is amended to read:

14103.6. The director, or a carrier acting under regulations adopted by the director, may require that any individual provider shall receive prior authorization before providing services when the director or carrier determines that the provider has been rendering unnecessary services.

At any time the director determines that it is necessary to postpone elective services pursuant to Section 14120, he or she shall require prior authorization for those services determined to be generally elective



under the provisions of Section 14103.4, except a service which costs less than one hundred dollars (\$100) or a lower amount determined by the director. This lower amount may be applied generally or for specific services. The director may terminate the requirement for prior authorization when he or she determines that it is no longer necessary to postpone elective services.

Prior authorization for services provided by persons licensed under the provisions of Chapter 4 (commencing with Section 1600) and Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code shall be determined by consultants licensed under Chapter 4 or Chapter 7 respectively. Prior authorization for all other elective services shall be determined by consultants licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, provided, however, that prior authorization for pharmaceutical services may be determined by persons licensed under the provisions of Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code, and prior authorization for services provided in an inpatient setting may be reviewed and approved, but not denied, by a person licensed under the provisions of Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, working under the supervision of a consultant licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

The consultants shall render decisions on prior authorization requests in a timely manner. A timely manner shall be deemed to be an average of five working days after the prior authorization request is received by the department. A decision shall be an approval, denial, modification, or request for additional information. A supplemental authorization request submitted with additional information requested by a consultant shall be processed in a timely manner as if it were an original authorization request. If no decision on a prior authorization request is rendered by the consultant within 30 days of receipt by the department, the request shall be deemed to be approved. Final decisions of the department on all requests for prior authorization shall be reviewable under the department's provider appeal and fair hearing procedures. If the request is denied, the department shall send notice to the provider and beneficiary of the right to appeal the decision.

In no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment.

In carrying out this section, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for staff to accomplish the treatment



authorization request reviews and medical case management, including appeals. The fiscal intermediary contract, including any contract amendment, system change pursuant to a change order, and project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, and any policies, procedures, or regulations authorized by those laws.

SEC. 53. Section 14105.18 is added to the Welfare and Institutions Code, to read:

14105.18. (a) Notwithstanding any other provision of law, provider rates of payment for services rendered in all of the following programs shall be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program.

(1) The California Children's Services Program established pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

(2) The Genetically Handicapped Person's Program established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

(3) The Breast and Cervical Cancer Early Detection Program established pursuant to Article 1.5 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code and the breast cancer programs specified in Section 30461.6 of the Revenue and Taxation Code.

(4) The State-Only Family Planning Program established pursuant to Division 24 (commencing with Section 24000).

(5) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program established pursuant to subdivision (aa) of Section 14132.

(b) The director may identify in regulations other programs not listed in subdivision (a) in which providers shall be paid rates of payment that are identical to the rates of payments in the Medi-Cal program pursuant to subdivision (a).

(c) Notwithstanding subdivision (a), services provided under any of the programs described in subdivisions (a) and (b) may be reimbursed at rates greater than the Medi-Cal rate that would otherwise be applicable if those rates are adopted by the director in regulations.

SEC. 53.5. Section 14105.2 of the Welfare and Institutions Code is amended to read:

14105.2. (a) The allowable markup payable for the dispensing of medical supplies by assistive device and sickroom supply dealers and



pharmacies shall not exceed 23 percent of the cost of the item dispensed, as defined by the department.

(b) Payment for diabetic testing supplies shall not exceed the cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.

SEC. 54. Section 14105.3 of the Welfare and Institutions Code is amended to read:

14105.3. (a) The department is considered to be the purchaser, but not the dispenser or distributor, of prescribed drugs under the Medi-Cal program for the purpose of enabling the department to obtain from manufacturers of prescribed drugs the most favorable price for those drugs furnished by one or more manufacturers, based upon the large quantity of the drugs purchased under the Medi-Cal program, and to enable the department, notwithstanding any other provision of state law, to obtain from the manufacturers discounts, rebates, or refunds based on the quantities purchased under the program, insofar as may be permissible under federal law. Nothing in this section shall interfere with usual and customary distribution practices in the drug industry.

(b) The department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies, and other product-type health care services and with laboratories for clinical laboratory services for the purpose of obtaining the most favorable prices to the state and to assure adequate quality of the product or service. This subdivision shall not apply to pharmacies licensed pursuant to Section 4080 of the Business and Professions Code.

(c) Notwithstanding subdivision (b), the department may not enter into a contract with a clinical laboratory unless the clinical laboratory operates in conformity with Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code and the regulations adopted thereunder, and Section 263a of Title 42 of the United States Code and the regulations adopted thereunder.

(d) The department shall contract with manufacturers of single-source drugs on a negotiated basis, and with manufacturers of multisource drugs on a bid or negotiated basis.

(e) In carrying out contracting activity for this or any section associated with the Medi-Cal list of contract drugs, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the contracting process or treatment authorization request reviews. The fiscal intermediary contract, including any contract amendment, system change pursuant to



a change order, and project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, and any policies, procedures, or regulations authorized by these provisions.

(f) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore contracts under this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) For purposes of implementing the contracting provisions specified in this section, the department shall do all of the following:

(1) Ensure adequate access for Medi-Cal patients to quality laboratory testing services in the geographic regions of the state where contracting occurs.

(2) Consult with the statewide association of clinical laboratories and other appropriate stakeholders on the implementation of the contracting provisions specified in this section to ensure maximum access for Medi-Cal patients consistent with the savings targets projected by the 2002–03 Budget Conference Committee for clinical laboratory services provided under the Medi-Cal program.

(3) Consider which types of laboratories are appropriate for implementing the contracting provisions specified in this section, including independent laboratories, outreach laboratory programs of hospital based laboratories, clinic laboratories, physician office laboratories, and group practice laboratories.

SEC. 55. Section 14105.31 of the Welfare and Institutions Code is amended to read:

14105.31. For purposes of the Medi-Cal contract drug list, the following definitions shall apply:

(a) “Single-source drug” means a drug that is produced and distributed under an original New Drug Application approved by the federal Food and Drug Administration. This shall include a drug marketed by the innovator manufacturer and any cross-licensed producers or distributors operating under the New Drug Application, and shall also include a biological product, except for vaccines, marketed by the innovator manufacturer and any cross-licensed producers or distributors licensed by the federal Food and Drug Administration pursuant to Section 262 of Title 42 of the United States Code. A drug ceases to be a single-source drug when the same drug in the same dosage form and strength manufactured by another manufacturer is approved by the federal Food and Drug Administration under the provisions for an Abbreviated New Drug Application.



(b) “Best price” means the negotiated price, or the manufacturer’s lowest price available to any class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer’s commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

(c) “Equalization payment amount” means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract. The equalization payment amount shall be based on the difference between the manufacturer’s direct catalog price charged to wholesalers and the manufacturer’s best price, as defined in subdivision (b).

(d) “Manufacturer” means any person, partnership, corporation, or other institution or entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or in the packaging, repackaging, labeling, relabeling, and distribution of drugs.

(e) “Price escalator” means a mutually agreed upon price specified in the contract, to cover anticipated cost increases over the life of the contract.

(f) “Medi-Cal pharmacy costs” or “Medi-Cal drug costs” means all reimbursements to pharmacy providers for services or merchandise, including single-source or multiple-source prescription drugs, over-the-counter medications, and medical supplies, or any other costs billed by pharmacy providers under the Medi-Cal program.

(g) “Medicaid rebate” means the rebate payment made by drug manufacturers pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(h) “State rebate” means any negotiated rebate under the Drug Discount Program in addition to the medicaid rebate.

(i) “Date of mailing” means the date that is evidenced by the postmark date by the United States Postal Service or other common mail carrier on the envelope.

SEC. 56. Section 14105.33 of the Welfare and Institutions Code is amended to read:

14105.33. (a) The department may enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or



nonbid basis, for drugs from each major therapeutic category, and shall maintain a list of those drugs for which contracts have been executed.

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer's best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed-upon price escalators, as defined in that section. The contracts shall provide for an equalization payment amount, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the equalization payment amount, including supporting utilization data from the department's prescription drug paid claims tapes within 30 days of receipt of the Centers for Medicare and Medicaid Services' file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department's mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance shall not be considered an accounts receivable amount until final resolution of the dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

(2) The department shall provide for an annual audit of utilization data used to calculate the equalization amount to verify the accuracy of that data. The findings of the audit shall be documented in a written audit report to be made available to manufacturers within 90 days of receipt of the report from the auditor. Any manufacturer may receive a copy of the audit report upon written request. Contracts between the department and manufacturers shall provide for any equalization payment adjustments determined necessary pursuant to an audit.

(3) Utilization data used to determine an equalization payment amount shall exclude data from both of the following:

(A) Health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that contract under Section 1396b(m) of Title 42 of the United States Code.

(B) Capitated plans that include a prescription drug benefit in the capitated rate, and that have negotiated contracts for rebates or discounts with manufacturers.



(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of therapeutic agents, the department shall ensure that there is representation on the list of contract drugs in all major therapeutic categories. Except as provided in subdivision (a) of Section 14105.35, the department shall not be required to contract with all manufacturers who negotiate for a contract in a particular category. The department shall ensure that there is sufficient representation of single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

(d) The department shall select the therapeutic categories to be included on the list of contract drugs, and the order in which it seeks contracts for those categories. The department may establish different contracting schedules for single-source and multiple-source drugs within a given therapeutic category.

(e) (1) In order to fully implement subdivision (d), the department shall, to the extent necessary, negotiate or renegotiate contracts to ensure there are as many single-source drugs within each therapeutic category or subcategory as the department determines necessary to meet the health needs of the Medi-Cal population. The department may determine in selected therapeutic categories or subcategories that no single-source drugs are necessary because there are currently sufficient multiple-source drugs in the therapeutic category or subcategory on the list of contract drugs to meet the health needs of the Medi-Cal population. However, in no event shall a beneficiary be denied continued use of a drug which is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within 30 business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

(f) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.



(h) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any drug from the list of contract drugs. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal.

(j) In carrying out the provisions of this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to initially accomplish the treatment authorization request reviews.

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates. The interest shall not apply to any prior period adjustments of unit rebate amounts or department utilization adjustments.

(2) For state rebate payments, manufacturers shall calculate and pay interest on late or unpaid rebates for quarters that begin on or after the effective date of the act that added this subdivision.

(3) Following final resolution of any dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with interest at the rate calculated pursuant to subdivisions (m) and (n), shall be credited by the department against future rebates due.

(l) Interest pursuant to subdivision (k) shall begin accruing 38 calendar days from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(m) Except as specified in subdivision (n), interest rates and calculations pursuant to subdivision (k) for medicaid rebates and state rebates shall be identical and shall be determined by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(n) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate and calculations pursuant



to subdivision (k) shall be as specified in subdivision (m), however the interest rate shall be increased by 10 percentage points. This subdivision shall apply to payments for amounts invoiced for any quarters that begin on or after the effective date of the act that added this subdivision.

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the manufacturer's contract with the department shall be deemed to be in default and the contract may be terminated in accordance with the terms of the contract. For all other manufacturers, if the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, all of the drug products of those manufacturers shall be made available only through prior authorization effective 270 days after the date of mailing of the invoice, including utilization data sent to manufacturers.

(p) If the manufacturer provides payment or evidence of payment to the department at least 40 days prior to the proposed date the drug is to be made available only through prior authorization pursuant to subdivision (o), the department shall terminate its actions to place the manufacturers' drug products on prior authorization.

(q) The department shall direct the state's fiscal intermediary to remove prior authorization requirements imposed pursuant to subdivision (o) and notify providers within 60 days after payment by the manufacturer of the rebate, including interest. If a contract was in place at the time the manufacturers' drugs were placed on prior authorization, removal of prior authorization requirements shall be contingent upon good faith negotiations and a signed contract with the department.

(r) A beneficiary may obtain drugs placed on prior authorization pursuant to subdivision (o) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the drug when its manufacturer is placed on prior authorization status. Additionally, the department shall have received a claim for the drug with a date of service that is within 100 days prior to the date the manufacturer was placed on prior authorization.

(s) A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the drug in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same drug.

(t) Drugs covered pursuant to Sections 14105.43 and 14133.2 shall not be subject to prior authorization pursuant to subdivision (o), and any



other drug may be exempted from prior authorization by the department if the director determines that an essential need exists for that drug, and there are no other drugs currently available without prior authorization that meet that need.

(u) It is the intent of the Legislature in enacting subdivisions (k) to (t), inclusive, that the department and manufacturers shall cooperate and make every effort to resolve rebate payment disputes within 90 days of notification by the manufacturer to the department of a dispute in the calculation of rebate payments.

SEC. 57. Section 14105.332 is added to the Welfare and Institutions Code, to read:

14105.332. State and federal rebates that are owed to the state for drugs dispensed to fee-for-service Medi-Cal beneficiaries shall not be reduced to the state if a manufacturer reports, to the Centers for Medicare and Medicaid Services or the department, a revised drug product's average manufacturer price or best price as these terms are defined pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) for any calendar quarter in which the rebate was due.

SEC. 58. Section 14105.337 of the Welfare and Institutions Code is amended to read:

14105.337. (a) Effective January 1, 2000, the department shall increase reimbursement to pharmacists by twenty-five cents (\$0.25) per prescription for all drug prescription claims reimbursed through the Medi-Cal program.

(b) Effective July 1, 2002, the department shall increase reimbursement to pharmacists by an additional fifteen cents (\$0.15) per prescription for all drug prescription claims reimbursed through the Medi-Cal program.

(c) (1) The department shall reduce reimbursement to pharmacists in the amount reimbursement was increased pursuant to subdivisions (a) and (b) with respect to pharmacy services rendered on and after the date that this subdivision is enacted. Claims submitted by pharmacists for beneficiaries residing in a nursing facility shall be exempt from this subdivision.

(2) This subdivision shall become inoperative on July 1, 2004.

SEC. 59. Section 14105.34 of the Welfare and Institutions Code is amended to read:

14105.34. (a) The department shall provide for an annual written report of Medi-Cal pharmacy costs or Medi-Cal drug costs, as defined in subdivision (f) of Section 14105.31.

(b) The annual report shall be consistent with the relevant sections of the Quarterly Report of Expenditures for the Medi-Cal Assistance Program, known as the HCFA-64 Report, provided to the Centers for



Medicare and Medicaid Services. The report shall include the following expenditure and receipt information:

(1) The total annual equalization payment amounts received by the department pursuant to agreements with the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(2) The total annual equalization payment amounts received pursuant to state contracts with drug manufacturers.

(3) Total drug cost amounts upon which equalization payments were made.

SEC. 60. Section 14105.35 of the Welfare and Institutions Code is amended to read:

14105.35. (a) (1) On and after July 1, 1990, drugs included on the Medi-Cal drug formulary shall be included on the list of contract drugs until the department and the manufacturer have concluded contract negotiations or the department suspends the drug from the list of contract drugs pursuant to the provisions of this subdivision.

The department shall, in writing, invite any manufacturer with single-source drug products on the formulary as of July 1, 1990, to enter into negotiations relative to the retention of its drug or drugs. As to the issue of cost, the department shall accept the manufacturer's best price as sufficient for purposes of entering into a contract to retain the drug or drugs on the list of contract drugs.

If the department and a manufacturer enter into a contract for retention of a drug or drugs on the list of contract drugs, the drug or drugs shall be retained on the list of contract drugs for the effective term of the contract.

If a manufacturer refuses to enter into negotiations with the department pursuant to this subdivision, or if after 30 days of negotiation, the manufacturer has not agreed to execute a contract for a drug at the manufacturer's best price, the department may suspend from the list of contract drugs the manufacturer's single-source drug in question for a period of at least 180 days. The department shall lift the suspension upon execution of a contract for that drug. Consistent with the provisions of this section, the department shall delete the Medi-Cal drug formulary specified in paragraphs (b), (c), (d), and (e) of Section 59999 of Title 22 of the California Code of Regulations.

(2) On and after July 1, 1990, the director may retain a drug on the Medi-Cal list of contract drugs even if no contract is executed with a manufacturer, if the director determines that an essential need exists for that drug, and there are no other drugs currently on the formulary that meet that need.



(3) The director may delete a drug from the list of contract drugs if the director determines that the drug presents problems of safety or misuse. The director's decision as to safety shall be based upon published medical literature, and the director's decision as to misuse shall be based on published medical literature and claims data supplied by the fiscal intermediary.

(b) Any reference to the Medi-Cal drug formulary by statute or regulation shall be construed as referring to the list of contract drugs.

(c) (1) Any drug in the process of being added to the formulary by contract agreement pursuant to Section 14105.3, executed prior to the effective date of this section, shall be added to the list of contract drugs.

(2) Contracts pursuant to Section 14105.3 executed prior to January 1, 1991, shall be considered to be contracts executed pursuant to Section 14105.33, and the department shall exempt the drugs included in these contracts from the initial therapeutic category review in which they would normally be considered.

(3) Nothing in this section shall be construed to require the department to discontinue negotiations into which it has entered with any manufacturer as of the effective date of this section. Contracts entered into as a result of these negotiations shall be exempt from the initial therapeutic category review in which they would normally be considered.

SEC. 61. Section 14105.37 of the Welfare and Institutions Code is amended to read:

14105.37. (a) The department shall notify each manufacturer of drugs in therapeutic categories selected pursuant to Section 14105.33 of the provisions of Sections 14105.31 to 14105.42, inclusive.

(b) If, within 45 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may suspend or delete from the list of contract drugs, or refuse to consider for addition, drugs of that manufacturer in the selected therapeutic categories.

(c) If, after 150 days from the initial notification, a contract is not executed for a drug currently on the list of contract drugs, the department may suspend or delete the drug from the list of contract drugs.

(d) If, within 150 days from the initial notification, a contract is executed for a drug currently on the list of contract drugs, the department shall retain the drug on the list of contract drugs.

(e) If, within 150 days from the date of the initial notification, a contract is executed for a drug not currently on the list of contract drugs, the department shall add the drug to the list of contract drugs.

(f) The department shall terminate all negotiations 150 days after the initial notification.



(g) The department may suspend or delete any drug from the list of contract drugs at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

(h) In the absence of a contract, the department may suspend or delete any drug from the list of contract drugs.

(i) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 shall be subject to prior authorization, as if that drug were not on the list of contract drugs.

(j) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 may be deleted from the list of contract drugs in accordance with Section 14105.38.

SEC. 62. Section 14105.38 of the Welfare and Institutions Code is amended to read:

14105.38. (a) (1) In the event the department determines a drug should be deleted from the list of contract drugs, the department shall conduct a public hearing, as provided in this section, to receive comment on the impact of removing the drug.

(2) (A) The department shall provide written notice 30 days prior to the hearing.

(B) The department shall send the notice required by this subdivision to the manufacturer of the drug proposed to be deleted and to organizations representing Medi-Cal beneficiaries.

(b) (1) The hearing panel shall consist of the Chief, Medi-Cal Drug Discount Program, who shall serve as chair, and the Medi-Cal Contract Drug Advisory Committee.

(2) The hearing shall be recorded and transcribed, and the transcript available for public review.

(3) Subsequent to hearing all public comment, and within 30 days of the hearing, each panel member shall submit a recommendation regarding deletion of the drug and the reason for the recommendation to the director.

(c) The director shall consider public comments provided at the hearing and the recommendations of each panel member in determining whether to delete the drug.

SEC. 63. Section 14105.39 of the Welfare and Institutions Code is amended to read:

14105.39. (a) (1) A manufacturer of a new single-source drug may request inclusion of its drug on the list of contract drugs pursuant to Section 14105.33 provided all of the following conditions are met:

(A) The request is made within 12 months of approval for marketing by the federal Food and Drug Administration.

(B) The manufacturer agrees to negotiate a contract with the department to provide the drug at the manufacturer's best price.



(C) (i) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(ii) Notwithstanding clause (i), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(I) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(II) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(D) The department had concluded contracting for the therapeutic category in which the drug is included prior to approval of the drug by the federal Food and Drug Administration.

(2) Within 90 days from receipt of the request, the department shall evaluate the request using the criteria identified in subdivision (d), and shall submit the drug to the Medi-Cal Contract Drug Advisory Committee.

(b) Any petition for the addition to or deletion of a drug to the Medi-Cal drug formulary submitted prior to July 31, 1990, shall be deemed to be denied. A manufacturer who has submitted a petition deemed denied may request inclusion of that drug on the list of contract drugs provided all of the following conditions are met:

(1) The manufacturer agrees to negotiate for a contract with the department to provide the drug at the manufacturer's best price.

(2) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(3) The manufacturer submits the request to the department prior to October 1, 1990.

(c) (1) To ensure that the health needs of Medi-Cal beneficiaries are met consistent with the intent of this chapter, the department shall, when evaluating a decision to execute a contract, and when evaluating drugs for retention on, addition to, or deletion from, the list of contract drugs, use all of the following criteria:

(A) The safety of the drug.

(B) The effectiveness of the drug.

(C) The essential need for the drug.

(D) The potential for misuse of the drug.

(E) The cost of the drug.

(2) The deficiency of a drug when measured by one of these criteria may be sufficient to support a decision that the drug should not be added or retained, or should be deleted from the list. However, the superiority of a drug under one criterion may be sufficient to warrant the addition



or retention of the drug, notwithstanding a deficiency in another criterion.

(d) (1) A manufacturer of single-source drugs denied a contract pursuant to this section or Section 14105.33 or 14105.37, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) Within 30 calendar days of the manufacturer's appeal, the director shall request a recommendation regarding the appeal from the Medi-Cal Contract Drug Advisory Committee. The committee shall provide its recommendation in writing, within 30 calendar days of the director's request.

(3) The director shall issue a final decision on the appeal within 30 calendar days of the recommendation.

(e) Deletions made to the list of contract drugs, including those made pursuant to Section 14105.37, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(f) A manufacturer of a drug deleted from, or not added to, the list of contract drugs may request inclusion of the drug on the list of preferred prior authorization drugs that is hereby established as a subset of the list of contract drugs. To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall evaluate the request pursuant to subdivision (c). The department shall give preference for prior authorization drugs based on the medical need or continuing care of the beneficiary. The department may contract with manufacturers of drugs on the list of preferred prior authorization drugs. Contracts executed pursuant to this subdivision are subject to Section 14105.33.

(g) Changes made to the list of contract drugs under this or any other section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

SEC. 64. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 78 of Chapter 93 of the Statutes of 2000, is repealed.

SEC. 65. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 77 of Chapter 93 of the Statutes of 2000, is amended to read:

14105.4. (a) The director shall appoint a Medi-Cal Contract Drug Advisory Committee for the purpose of providing scientific and medical analysis on drugs contained on the list of contract drugs. The duties of the committee shall be as follows:



(1) To review drugs in the Medi-Cal list of contract drugs and make written recommendations to the director as to the addition of any drug or the deletion of any drug from the list. These recommendations shall be in accordance with subdivision (c) of Section 14105.39.

(2) To review and report in writing to the director as to the comparative therapeutic effect of drugs in accordance with Section 14053.5.

(3) To prepare a fair, impartial, and independent recommendation in writing, regarding appeals from manufacturers made pursuant to subdivision (d) of Section 14105.39.

(b) The committee shall consist of at least one representative from each of the following groups:

(1) Physicians.

(2) Pharmacists.

(3) Schools of pharmacy or pharmacologists.

(4) Medi-Cal beneficiaries.

(c) Members of the committee shall be reimbursed for necessary travel and other expenses incurred in the performance of official committee duties.

(d) In order to provide sufficient scientific information and analysis in the therapeutic categories under review, the director may replace a representative if required for specific expertise.

(e) The director shall notify the committee of the decisions made on the recommendations.

SEC. 66. Section 14105.405 of the Welfare and Institutions Code is amended to read:

14105.405. (a) A Medi-Cal beneficiary, within 90 days of receipt of the director's notice to beneficiaries pursuant to subdivision (i) of Section 14105.33, informing them of the decision to delete or suspend a drug from the list of contract drugs, may request a fair hearing pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(b) Any beneficiary filing a fair hearing request regarding the deletion or suspension of a drug from the list of contract drugs shall be granted a treatment authorization request for that drug until a final decision is adopted by the director. Should the beneficiary seek judicial review of the director's decision, a treatment authorization request shall be granted for that drug until a final decision is issued by the court.

(c) (1) Any Medi-Cal beneficiary, within one year of the director's decision pursuant to Section 10959, may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure, praying for a review of both the legal and factual basis for the director's decision.

(2) The director shall be the sole respondent in these proceedings.



(d) Any Medi-Cal beneficiary injured as a result of being denied a drug which is determined to be medically necessary may sue for injunctive or declaratory relief to review the director's decision to delete or suspend a drug from the list of contract drugs.

SEC. 67. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 81 of Chapter 93 of the Statutes of 2000, is repealed.

SEC. 68. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 80 of Chapter 93 of the Statutes of 2000, is amended to read:

14105.41. Moneys accruing to the department from contracts executed pursuant to Section 14105.33 shall be deposited in the Health Care Deposit Fund, and shall be subject to appropriation by the Legislature.

SEC. 69. Section 14105.42 of the Welfare and Institutions Code is amended to read:

14105.42. (a) The department shall report to the Legislature after the first three major therapeutic categories have been reviewed and contracts executed. The report shall include the estimated savings, number of manufacturers entering negotiations, number of contracts executed, number of drugs added and deleted, and impact on Medi-Cal beneficiaries and providers.

(b) The department shall report to the Legislature, through the annual budget process, on the cost-effectiveness of contracts executed pursuant to Section 14105.33.

SEC. 70. Section 14105.43 of the Welfare and Institutions Code is amended to read:

14105.43. (a) (1) Notwithstanding other provisions of this chapter, any drug which is approved by the federal Food and Drug Administration for use in the treatment of acquired immune deficiency syndrome (AIDS) or an AIDS-related condition shall be deemed to be approved for addition to the Medi-Cal list of contract drugs only for the purpose of treating AIDS or an AIDS-related condition, for the period prior to the completion of the procedures established pursuant to Section 14105.33.

(2) (A) In addition to any drug that is deemed to be approved pursuant to paragraph (1), any drug that meets any of the following criteria shall be a Medi-Cal benefit, subject to utilization controls:

(i) Any vaccine to protect against human immunodeficiency virus (HIV) infection.

(ii) Any antiviral agent, immune modulator, or other agent to be administered to persons who have been infected with human immunodeficiency virus to counteract the effects of that infection.



(iii) Any drug or biologic used to treat opportunistic infections associated with acquired immune deficiency syndrome, that have been found to be medically accepted indications and that has either been approved by the federal Food and Drug Administration or recognized for that use in one of the following:

(I) The American Medical Association Drug Evaluations.

(II) The United States Pharmacopoeia Dispensing Information.

(III) Two articles from peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective.

(iv) Any drug or biologic used to treat the chemotherapy-induced suppression of the human immune system resulting from the treatment of acquired immune deficiency syndrome.

(3) The department shall add any drug deemed to be approved pursuant to paragraph (1) to the Medi-Cal list of contract drugs or allow the provision of the drug as a Medi-Cal benefit, subject to utilization controls, pursuant to paragraph (2), only if the manufacturer of the drug has executed a contract with the Centers for Medicare and Medicaid Services which provides for rebates in accordance with Section 1396r-8 of Title 42 of the United States Code.

(b) Any drug deemed to be approved pursuant to paragraph (1) of subdivision (a) shall be immediately added to the Medi-Cal list of contract drugs, and shall be exempt from the contract requirements of Section 14105.33.

(c) If it is determined pursuant to subdivision (c) of Section 14105.39 that a drug to which subdivision (a) applies should not be placed on the Medi-Cal list of contract drugs, that drug shall no longer be deemed to be approved for addition to the list of contract drugs pursuant to subdivision (a).

SEC. 71. Section 14105.436 is added to the Welfare and Institutions Code, to read:

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 and reimbursed through the Medi-Cal outpatient fee-for-service drug program. The state rebate shall be negotiated as necessary between the department and the pharmaceutical manufacturer. The negotiations shall take into account offers such as rebates, discounts, disease management programs, and other cost savings offerings and shall be retroactive to July 1, 2002.

(b) The department may use existing administrative mechanisms for any drug for which the department does not obtain a rebate pursuant to subdivision (a). The department may only use those mechanisms in the



event that, by February 1, 2003, the manufacturer refuses to provide the additional rebate.

(c) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy and that is the subject of an administrative mechanism pursuant to subdivision (b) until the prescribed therapy is no longer prescribed.

(d) This section shall become inoperative on July 1, 2005, and, as of January 1, 2006, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2006, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 72. Section 14105.45 of the Welfare and Institutions Code is amended to read:

14105.45. (a) The department shall establish a list of Maximum Allowable Ingredient Costs (MAIC) for drugs, which shall be published in provider bulletins. On the effective date of this section, MAICS listed in Title 22 of the California Code of Regulations shall be included in the list of MAICS. MAICS shall no longer be listed in regulations. The department shall repeal Section 51513.3 of Title 22 of the California Code of Regulations.

(b) The department shall update existing MAICS and establish additional MAICS in accordance with all of the following:

(1) The department shall base an MAIC on the mean of the wholesale selling prices of drugs generically equivalent to the innovator brand that are available in California from selected major wholesale drug distributors. For the purposes of this section, “wholesale selling price” means the price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor for a drug.

(2) The decision regarding therapeutic equivalency shall be based on the federal Food and Drug Administration determinations. For antacid drugs, therapeutic equivalency shall be determined by the department based on review of in vitro scientific data.

(3) The department shall request information from drug manufacturers regarding the availability of their products throughout the state to outpatient pharmacies through the usual and customary distribution channels in sufficient quantities to meet the needs of the Medi-Cal program.

(4) The department shall update MAICS at least every two months and notify Medi-Cal providers at least 30 days prior to the effective date of an MAIC.

(c) Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, actions under this section shall not be subject to the Administrative



Procedure Act, or to the review and approval of the Office of Administrative Law.

SEC. 73. Section 14105.46 is added to the Welfare and Institutions Code, to read:

14105.46. (a) For purposes of this section, the following definitions apply:

(1) “Estimated acquisition cost” means the department’s best estimate of the price generally and currently paid by providers for a drug product sold by a particular manufacturer or principal labeler in a standard package.

(2) “Legend” means any drug whose labeling states “Caution: Federal law prohibits dispensing without prescription” or words of similar import.

(3) “Nonlegend” means any drug whose labeling does not contain the statement referenced in paragraph (2).

(4) “Single-source,” “innovator multiple source,” and “noninnovator multiple source” drugs have the same meaning as those terms are defined in Section 1396r-8(k)(7) of Title 42 of the United States.

(5) “Average sales price” means the price reported to the department as required by agreements between the State of California and the manufacturer.

(6) “Average wholesale price” means the price for a drug product listed in the department’s price reference source.

(7) “Direct price” means the price for a drug product purchased directly from a drug manufacturer listed in the department’s price reference source.

(b) The department shall establish the estimated acquisition cost of legend and nonlegend drugs as follows:

(1) For single-source and innovator multiple source drugs, the estimated acquisition cost shall be equal to the lower of the average sales price, as reported to the department by a drug manufacturer, and the average wholesale price minus 10 percent.

(2) For noninnovator multiple source drugs, the estimated acquisition cost shall be equal to the lower of the average sales price, as reported to the department by a drug manufacturer, and the average wholesale price minus 10 percent.

(c) Direct price shall not be used by the department to establish estimated acquisition cost.

(d) The reimbursement for legend and nonlegend drugs shall consist of the cost of the drug plus a professional fee for services.

SEC. 74. Section 14105.47 is added to the Welfare and Institutions Code, to read:

14105.47. (a) (1) The department shall establish a list of medical supplies. The list shall specify utilization controls to be applied to each medical supply product.

(2) The utilization controls specified shall include, but not be limited to, those provided by regulation of the department. The department shall repeal Section 59998 of Title 22 of the California Code of Regulations, which establishes requirements for medical supplies.

(3) The department shall notify providers at least 30 days prior to the effective date of a change in utilization controls.

(b) (1) The department shall establish a list of maximum allowable product costs (MAPCS) for medical supplies, which shall be published in provider bulletins.

(2) The department shall repeal the provisions of Section 51520.1 of Title 22 of the California Code of Regulations.

(3) The department shall update existing MAPCS and establish additional MAPCS in accordance with all of the following:

(A) In establishing the MAPCS, the director shall assure that eligible persons shall receive medical supply products that are available to the public generally, without discrimination or segregation based purely on economic disability.

(B) All related medical supply products within each particular medical supply type available for retail distribution shall be reviewed by the department in consultation with representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association.

(C) The department shall base MAPCS on the mean of the wholesale selling price of related medical supply products that are available in California. For purposes of this section, “wholesale selling price” means the price, including discounts and rebates, paid by a provider to a wholesaler, distributor, or manufacturer for a medical supply product.

(D) The department shall notify Medi-Cal providers at least 30 days prior to the effective date of MAPCS.

(c) Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, actions under this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

SEC. 75. Section 14105.65 of the Welfare and Institutions Code is repealed.

SEC. 76. Section 14105.8 is added to the Welfare and Institutions Code, to read:

14105.8. (a) The department may enter into contracts with manufacturers of enteral formulae that can be used as a therapeutic regimen to prevent serious disability or death in patients with medically



diagnosed conditions that preclude the full use of regular food, on a bid or nonbid basis. The department shall maintain a list of those products for which contracts have been executed. Rebates created by these contracts shall be managed through the department's drug rebate accounting system.

(b) For the purpose of this benefit, enteral formulae is defined as those products that have been classified by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) into one of the product classifications used for reimbursement in the Medicare program. SADMERC classified enteral formulae, Category V: modular components do not meet the test as a replacement for regular food pursuant to subdivision (a) and shall not be a benefit of the Medi-Cal program, except that the Medi-Cal program may deem a SADMERC Category V classified enteral formulae as a benefit when the department determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions. Infant formulas and enteral formulae covered by the Woman, Infant and Children (WIC) program for individuals enrolled in WIC shall not be a benefit of the Medi-Cal program.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of enteral formulae pursuant to subdivision (a), the department shall ensure that there is representation on the list of both general use and specialized use enteral formulae. The Medi-Cal program may deem an enteral formulae not classified by SADMERC as a benefit if it meets the medical need of patients with medically diagnosed conditions that preclude the full use of regular food.

(d) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(e) (1) A manufacturer of an enteral formulae denied a contract pursuant to this section may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) The director shall issue a final decision on the appeal within 60 calendar days of the postmark date of the appeal.

(f) Deletions made to the list of enteral formulae shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(g) Changes made to the list of enteral formulae under this or any other section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter



4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

(h) In no event shall a beneficiary be denied continued use of an enteral formulae, pursuant to subdivisions (b) and (j), that has been deleted from the list of enteral formulae. To be eligible for continuing care status under this subdivision, a beneficiary must be taking the enteral formulae product when the product is deleted. Additionally, the department shall have received a claim for the enteral formulae product with a date of service that is within 100 days prior to the date the product was deleted. A beneficiary shall remain eligible for continuing care status provided that a claim is submitted for the enteral formulae product in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same enteral formulae product.

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion of any enteral formulae from the list of enteral formulae. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute enteral formulae is available from Medi-Cal.

(j) Enteral formulae authorized pursuant to subdivision (a) shall be available only through prior authorization. The department may designate those enteral formulae that are without a contract as not being a benefit of the Medi-Cal program, except in the case of continuing care as described in subdivision (h) of this section.

(k) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(l) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates.

(2) Interest pursuant to paragraph (1) shall begin accruing 38 calendar days from the date of mailing of the quarterly invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(3) Interest rates and calculations pursuant to paragraph (1) shall be identical and shall be equal to the drug rebate interest rates as determined by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.



(4) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate shall be as specified in paragraph (3), however the interest rate shall be increased by 10 percentage points.

(m) The department may adopt emergency regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 77. Section 14105.85 is added to the Welfare and Institutions Code, to read:

14105.85. Effective July 1, 2002, payment for enteral formulae dispensed by a pharmacy provider shall be based on the estimated acquisition cost for that product plus a percentage markup to be determined by the department in consultation with provider representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association. The percentage markup shall consider the costs of handling, storage, delivery, and billing for those products. Any changes to the percentage markup may be implemented with 30-day notice to the provider community via a provider bulletin or other specific notification to providers.

SEC. 78. Section 14105.91 of the Welfare and Institutions Code is repealed.

SEC. 79. Section 14105.915 of the Welfare and Institutions Code is repealed.

SEC. 80. Section 14105.916 of the Welfare and Institutions Code is repealed.

SEC. 81. Section 14125 of the Welfare and Institutions Code is amended to read:

14125. The purpose of this article is to establish provider reimbursement rates for incontinence medical supplies covered by the Medi-Cal program. Reimbursement for incontinence medical supplies shall consist of the weighted average of the negotiated contract prices within each product category, plus a markup fee equal to 38 percent of the resulting adjusted contract price.

SEC. 83. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services



of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. The department's utilization controls shall not require X-rays as a condition of reimbursement for fillings for children under 18 years of age. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment



or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when



necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.



(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

- (1) Level of care and cost of care evaluations.
- (2) Expenses, directly attributable to home care activities, for materials.
- (3) Physician fees for home visits.
- (4) Expenses directly attributable to home care activities for shelter and modification to shelter.
- (5) Expenses directly attributable to additional costs of special diets, including tube feeding.
- (6) Medically related personal services.
- (7) Home nursing education.
- (8) Emergency maintenance repair.
- (9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.
- (10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.
- (11) Emergency and nonemergency medical transportation.
- (12) Medical supplies.
- (13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.
- (14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.
- (15) Special drugs and medications.



(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the



requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject



to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing



with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, “comprehensive clinical family planning services” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

- (i) Psychosocial and medical aspects of contraception.
- (ii) Sexuality.
- (iii) Fertility.
- (iv) Pregnancy.
- (v) Parenthood.
- (vi) Infertility.
- (vii) Reproductive health care.



- (viii) Preconception and nutrition counseling.
- (ix) Prevention and treatment of sexually transmitted infection.
- (x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.
- (xi) Possible contraceptive consequences and followup.
- (xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 84. Section 14132.26 of the Welfare and Institutions Code is amended to read:

14132.26. (a) The department shall develop a program that requires a waiver of federal law to test the efficacy of providing an assisted living benefit to beneficiaries under the Medi-Cal program. Assisted living benefits shall include, but are not limited to, the care and supervision activities specified in Section 1569.2 of the Health and Safety Code and Section 87101 of Title 22 of the California Code of Regulations, and other health-related services. The program developed pursuant to this section shall be known as the waiver program for purposes of this section. The department shall submit any necessary waiver applications or modifications to the medicaid state plan to the Health Care Financing Administration to implement the waiver program, and shall implement the waiver program only to the extent federal financial participation is available.

(b) The department shall develop the waiver program in conjunction with other state departments, consumers, consumer advocates, housing and service providers, and experts in the fields of gerontology, geriatric health, nursing services, and independent living.

(c) The assisted living benefit shall be designed to provide eligible individuals with a range of services that enable them to remain in the least restrictive and most homelike environment while receiving the medical and personal care necessary to protect their health and well-being. Benefits provided pursuant to this waiver program shall



include only those not otherwise available under the state plan, and may include, but are not limited to, medicine management, coordination with a primary health care provider, and case management.

(d) (1) Eligible individuals shall be those who are eligible for the Medi-Cal program and are determined by the department to be eligible for placement in a nursing facility, as defined under subdivisions (c) and (d) of Section 1250 of the Health and Safety Code. Eligibility shall be based on an assessment of an individual's ability to perform functional and instrumental activities of daily living, as well as the individual's medical diagnosis and prognosis, and other criteria, including other Medi-Cal services that the beneficiary is receiving, as specified in the waiver.

(2) An eligible individual shall participate in the waiver program only if he or she is fully informed of the program and the nature of the assisted living benefit and indicates in writing his or her choice to participate.

(e) (1) The waiver program shall test the effectiveness of providing a Medi-Cal assisted living benefit through two service delivery approaches, as specified in paragraphs (2) and (3).

(2) Under the first model, an assisted living benefit shall be provided to residents of licensed residential care facilities. Facility participation in the program shall be determined by the department in conjunction with the State Department of Social Services and in accordance with the criteria for participation specified in the waiver. Under this model the facility operator shall be responsible for the provision of services allowed under the benefit, either directly or through contracts with other provider agencies, as permitted and specified in the waiver. During participation in the waiver program, residential care facilities shall comply with all terms and conditions of the waiver. The department and the State Department of Social Services, may, as determined necessary and appropriate, waive provisions contained in Division 2 (commencing with Section 1200) of the Health and Safety Code, subdivision (h) of Section 14132.95, and Title 22 of the California Code of Regulations for facilities providing services to waiver program participants.

(3) Under the second model, an assisted living benefit shall be provided to residents in publicly funded senior and disabled housing projects. Under this model an independent agency, pursuant to a contract with the department, shall be responsible for the provision of case management and other services to eligible individuals, as specified in the waiver.

(f) The department shall evaluate the effectiveness of the waiver program.

(1) The evaluation shall include, but not be limited to, participant satisfaction, health, and safety, the quality of life of the participant



receiving the assisted living benefit, and demonstration of the cost neutrality of the waiver program as specified in federal guidelines.

(2) The evaluation shall estimate the projected savings, if any, in the budgets of state and local governments if the program was expanded statewide.

(3) The evaluation shall be submitted to the appropriate policy and fiscal committees of the Legislature on or before January 1, 2003.

(g) The department shall limit the number of participants in the waiver program during the initial three years of its operation to a number that will be statistically significant for purposes of the program evaluation and that meets any requirements of the federal Health Care Financing Administration, including a request to waive statewide implementation requirements for the waiver program during the initial years of evaluation.

(h) In implementing this section, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this section may be on a noncompetitive bid basis, and shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(i) The department shall not implement the waiver program specified in subdivision (a) if the benefits provided pursuant to the waiver program will result in additional costs to the Medi-Cal program.

(j) The waiver program shall be developed and implemented only to the extent that funds are appropriated or otherwise available for that purpose.

SEC. 85. Section 14132.73 is added to the Welfare and Institutions Code, to read:

14132.73. The State Department of Health Services shall allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telemedicine until June 30, 2004, or until the State Department of Mental Health and mental health plans, in collaboration with stakeholders, develop a method for reimbursing psychiatric services provided through telemedicine that is administratively feasible for the mental health plans, primary care providers, and psychiatrists providing the services, whichever occurs later.

SEC. 85.5. Section 14132.88 of the Welfare and Institutions Code is amended to read:

14132.88. (a) Notwithstanding subdivision (h) of Section 14132 and to the extent funds are made available in the annual Budget Act for this purpose, the following are covered benefits for beneficiaries 21 years of age or older under this chapter:



- (1) One dental prophylaxis cleaning per year.
- (2) One initial dental examination by a dentist.

(b) The following are covered benefits for beneficiaries under 21 years of age under this chapter:

- (1) Two dental prophylaxis cleanings per year.
- (2) Two periodic dental examinations per year.

SEC. 86. Section 14132.95 of the Welfare and Institutions Code is amended to read:

14132.95. (a) Personal care services, when provided to a categorically needy person as defined in Section 14050.1 is a covered benefit to the extent federal financial participation is available if these services are:

- (1) Provided in the beneficiary's home and other locations as may be authorized by the director subject to federal approval.
- (2) Authorized by county social services staff in accordance with a plan of treatment.
- (3) Provided by a qualified person.
- (4) Provided to a beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services described in this section.

(b) The department shall seek federal approval of a state plan amendment necessary to include personal care as a medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations. For any persons who meet the criteria specified in subdivision (a) or (p), but for whom federal financial participation is not available, eligibility shall be available pursuant to Article 7 (commencing with Section 12300) of Chapter 3, if otherwise eligible.

(c) Subdivision (a) shall not be implemented unless the department has obtained federal approval of the state plan amendment described in subdivision (b), and the Department of Finance has determined, and has informed the department in writing, that the implementation of this section will not result in additional costs to the state relative to state appropriation for in-home supportive services under Article 7 (commencing with Section 12300) of Chapter 3, in the 1992–93 fiscal year.

(d) (1) For purposes of this section, personal care services shall mean all of the following:

- (A) Assistance with ambulation.
- (B) Bathing, oral hygiene and grooming.
- (C) Dressing.
- (D) Care and assistance with prosthetic devices.



- (E) Bowel, bladder, and menstrual care.
- (F) Skin care.
- (G) Repositioning, range of motion exercises, and transfers.
- (H) Feeding and assurance of adequate fluid intake.
- (I) Respiration.
- (J) Paramedical services.
- (K) Assistance with self-administration of medications.

(2) Ancillary services including meal preparation and cleanup, routine laundry, shopping for food and other necessities, and domestic services may also be provided as long as these ancillary services are subordinate to personal care services. Ancillary services may not be provided separately from the basic personal care services.

(e) (1) (A) After consulting with the State Department of Social Services, the department shall adopt emergency regulations to establish the amount, scope, and duration of personal care services available to persons described in subdivision (a) in the fiscal year whenever the department determines that General Fund expenditures for personal care services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, are expected to exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992–93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute. At least 30 days prior to filing these regulations with the Secretary of State, the department shall give notice of the expected content of these regulations to the fiscal committees of both houses of the Legislature.

(B) In establishing the amount, scope, and duration of personal care services, the department shall ensure that General Fund expenditures for personal care services provided for under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, do not exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992–93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute.

(C) For purposes of this subdivision, “caseload growth” means an adjustment factor determined by the department based on (1) growth in the number of persons eligible for benefits under Chapter 3



(commencing with Section 12000) on the basis of their disability, (2) the average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1988–89 to 1992–93 fiscal years, inclusive, due to the level of impairment, and (3) any increase in program costs that is required by an increase in the mandatory minimum wage.

(2) In establishing the amount, scope, and duration of personal care services pursuant to this subdivision, the department may define and take into account, among other things:

(A) The extent to which the particular personal care services are essential or nonessential.

(B) Standards establishing the medical necessity of the services to be provided.

(C) Utilization controls.

(D) A minimum number of hours of personal care services that must first be assessed as needed as a condition of receiving personal care services pursuant to this section.

The level of personal care services shall be established so as to avoid, to the extent feasible within budgetary constraints, medical out-of-home placements.

(3) To the extent that General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1992–93 fiscal year, adjusted for caseload growth, exceed General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in any fiscal year, the excess of these funds shall be expended for any purpose as directed in the Budget Act or as otherwise statutorily disbursed by the Legislature.

(f) Services pursuant to this section shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program. A provider of personal care services shall be qualified to provide the service and shall be a person other than a member of the family. For purposes of this section, a family member means a parent of a minor child or a spouse.

(g) A beneficiary who is eligible for assistance under this section shall receive services that do not exceed 283 hours per month of personal care services.



(h) Personal care services shall not be provided to residents of facilities licensed by the department, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the Community Care Licensing Division of the State Department of Social Services.

(i) Subject to any limitations that may be imposed pursuant to subdivision (e), determination of need and authorization for services shall be performed in accordance with Article 7 (commencing with Section 12300) of Chapter 3.

(j) (1) To the extent permitted by federal law, reimbursement rates for personal care services shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, plus any increase provided in the annual Budget Act for personal care services rates or included in a county budget pursuant to paragraph (2).

(2) (A) The department shall establish a provider reimbursement rate methodology to determine payment rates for the individual provider mode of service that does all of the following:

(i) Is consistent with the functions and duties of entities created pursuant to Section 12301.6.

(ii) Makes any additional expenditure of state general funds subject to appropriation in the annual Budget Act.

(iii) Permits county-only funds to draw down federal financial participation consistent with federal law.

(B) This ratesetting method shall be in effect in time for any rate increases to be included in the annual Budget Act.

(C) The department may, in establishing the ratesetting method required by subparagraph (A), do both of the following:

(i) Deem the market rate for like work in each county, as determined by the Employment Development Department, to be the cap for increases in payment rates for individual practitioner services.

(ii) Provide for consideration of county input concerning the rate necessary to ensure access to services in that county.

(D) If an increase in individual practitioner rates is included in the annual Budget Act, the state-county sharing ratio shall be as established in Section 12306. If the annual Budget Act does not include an increase in individual practitioner rates, a county may use county-only funds to meet federal financial participation requirements consistent with federal law.

(3) (A) By November 1, 1993, the department shall submit a state plan amendment to the federal Health Care Financing Administration to implement this subdivision. To the extent that any element or requirement of this subdivision is not approved, the department shall

submit a request to the federal Health Care Financing Administration for any waivers as would be necessary to implement this subdivision.

(B) The provider reimbursement ratesetting methodology authorized by the amendments to this subdivision in the 1993–94 Regular Session of the Legislature shall not be operative until all necessary federal approvals have been obtained.

(k) (1) The State Department of Social Services shall, by September 1, 1993, notify the following persons that they are eligible to participate in the personal care services program:

(A) Persons eligible for services pursuant to the Pickle Amendment, as adopted October 28, 1976.

(B) Persons eligible for services pursuant to subsection (c) of Section 1383c of Title 42 of the United States Code.

(2) The State Department of Social Services shall, by September 1, 1993, notify persons to whom paragraph (1) applies and who receive advance payment for in-home supportive services that they will qualify for services under this section without a share of cost if they elect to accept payment for services on an arrears rather than an advance payment basis.

(l) An individual who is eligible for services subject to the maximum amount specified in subdivision (b) of Section 12303.4 shall be given the option of hiring his or her own provider.

(m) The county welfare department shall inform in writing any individual who is potentially eligible for services under this section of his or her right to the services.

(n) It is the intent of the Legislature that this entire section be an inseparable whole and that no part of it be severable. If any portion of this section is found to be invalid, as determined by a final judgment of a court of competent jurisdiction, this section shall become inoperative.

(o) Paragraphs (2) and (3) of subdivision (a) shall be implemented so as to conform to federal law authorizing their implementation.

(p) (1) Personal care services shall be provided as a covered benefit to a medically needy aged, blind, or disabled person, as defined in subdivision (a) of Section 14051, to the same extent and under the same requirements as they are provided under subdivision (a) of this section to a categorically needy, aged, blind, or disabled person, as defined in subdivision (a) of Section 14050.1, and to the extent that federal financial participation is available.

(2) The department shall seek federal approval of a state plan amendment necessary to include personal care services described in paragraph (1) as a medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations.



(3) In the event that the Department of Finance determines that expenditures of both General Fund moneys for personal care services provided under this subdivision to medically needy aged, blind, or disabled persons together with expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for all aged, blind, and disabled persons receiving in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, in the 2000–01 fiscal year or in any subsequent fiscal year, are expected to exceed the General Fund appropriation and the federal appropriation received under Title XX of the federal Social Security Act for expenditures for all aged, blind, and disabled persons receiving in-home supportive services provided in the 1999–2000 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1998, as adjusted for caseload growth or as changed in the Budget Act or by statute or regulation, then this subdivision shall cease to be operative on the first day of the month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of the Department of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(4) Solely for purposes of paragraph (3), caseload growth means an adjustment factor determined by the department based on:

(A) Growth in the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability.

(B) The average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1994–95 to 1998–99 fiscal years, inclusive, due to the level of impairment.

(C) Any increase in program cost that is required by an increase in hourly costs pursuant to the Budget Act or statute.

(5) In the event of a final judicial determination by any court of appellate jurisdiction or a final determination by the Administrator of the federal Centers for Medicare and Medicaid Services that personal care services must be provided to any medically needy person who is not aged, blind, or disabled, then this subdivision shall cease to be operative on the first day of the first month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the



appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(6) If this subdivision ceases to be operative, all aged, blind, and disabled persons who would have received or been eligible to receive in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, but for receiving services under this subdivision, shall be eligible immediately upon this section becoming inoperative for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(7) The department shall implement this subdivision on April 1, 1999, but only if the department has obtained federal approval of the state plan amendments described in paragraph (2) of this subdivision.

SEC. 87. Section 14150 is added to the Welfare and Institutions Code, to read:

14150. Within 60 calendar days of the date that the annual Budget Act is chaptered, the department shall notify the chairpersons of the fiscal committees of each house of the Legislature, the Chairperson and the Vice Chairperson of the Joint Legislative Budget Committee, and appropriate county representatives if the department plans to withhold and not allocate any of the baseline allocation for county Medi-Cal eligibility activities that are appropriated for Medi-Cal administration.

SEC. 88. Section 14163 of the Welfare and Institutions Code is amended to read:

14163. (a) For purposes of this section, the following definitions shall apply:

(1) "Public entity" means a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

(2) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(3) "Disproportionate share hospital" means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) "Disproportionate share list" means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

(6) "Eligible hospital" means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive



payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) “Transfer year” means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) “Transferor entity” means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) “Transfer amount” means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) “Intergovernmental transfer” means a transfer of funds from a public entity to the state, that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) “Licensee” means an entity that has been issued a license to operate a hospital by the department.

(12) “Annualized Medi-Cal inpatient paid days” means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) “Medi-Cal acute inpatient hospital day” means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(14) “OBRA 1993 payment limitation” means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code as implemented pursuant to the Medi-Cal State Plan.

(b) The Medi-Cal Inpatient Payment Adjustment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to applicable provisions of this section or obtained by offset pursuant to subdivision (j).



(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164.

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any provision of law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Transfers to the Health Care Deposit Fund as follows:

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety dollars (\$239,757,690) for the 1994–95 and 1995–96 fiscal years.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars (\$229,757,690) for the 1996–97 fiscal year.

(C) In the amount of one hundred fifty-four million seven hundred fifty-seven thousand six hundred ninety dollars (\$154,757,690) for the 1997–98 fiscal year.

(D) In the amount of one hundred fourteen million seven hundred fifty-seven thousand six hundred ninety dollars (\$114,757,690) for the 1998–99 fiscal year.

(E) (i) In the amount of eighty-four million seven hundred fifty-seven thousand six hundred ninety dollars (\$84,757,690) for the 1999–2000 fiscal year.

(ii) It is the intent of the Legislature that the economic benefit of any reduction in the amount transferred, or to be transferred, to the Health Care Deposit Fund pursuant to this subdivision for the 1999–2000 fiscal year, as compared to the amount so transferred for the 1998–99 fiscal year, be allocated equally between public and nonpublic disproportionate share hospitals. To implement the reduction in clause (i) the department shall, by June 30, 2000, adjust the calculations in Section 14105.98 in order to allocate the funds in accordance with this clause.

(F) In the amount of twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars (\$29,757,690) for the 2000–01 fiscal year and the 2001–02 fiscal year.



(G) In the amount of eighty-five million dollars (\$85,000,000) for the 2002–03 fiscal year and each fiscal year thereafter.

(H) The transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-0001 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year issued by the department pursuant to paragraph (1) of subdivision (f) of Section 14105.98. The department shall identify each eligible hospital on the list for which a public entity is the licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product



of this calculation for each hospital in paragraph (2) shall be divided by 1.771, yielding a transfer amount for the particular transferor entity for the transfer year.

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts.

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under Section 14105.98 for the particular year in question, including any decreases resulting from the application of the OBRA 1993 payment limitation. The department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities by the department shall meet the requirements set forth in subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98, exclusive of the amounts described in paragraph (2) of this subdivision, and to satisfy the requirements of paragraph (2) of subdivision (d), for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(F) The following provisions shall apply for certain transfer amounts relating to nonsupplemental payments under Section 14105.98:

(i) For the 1998–99 transfer year, transfer amounts shall be determined as though the payment adjustment amounts arising pursuant to subdivision (ag) of Section 14105.98 were increased by the amounts paid or payable pursuant to subdivision (af) of Section 14105.98.



(ii) Any transfer amounts paid by a transferor entity pursuant to subparagraph (C) of paragraph (2) shall serve as credit for the particular transferor entity against an equal amount of its transfer obligation for the 1998–99 transfer year.

(iii) For the 1999–2000 transfer year, transfer amounts shall be determined as though the amount to be transferred to the Health Care Deposit Fund, as referred to in paragraph (2) of subdivision (d), were reduced by 28 percent.

(2) (A) Except as provided in subparagraphs (B), (C), and (D), for the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental payment adjustment amounts of all types that arise under Section 14105.98. These increases shall be paid only by those transferor entities that are licensees of hospitals that are projected to receive some or all of the particular supplemental payments, and the increases shall be paid by the transferor entities on a pro rata basis in connection with the particular supplemental payments. For purposes of this paragraph, supplemental payment adjustment amounts shall be deemed to arise for the particular transfer year as of the date specified in Section 14105.98. Transfer amounts to fund the nonfederal share of the payments shall be paid for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(B) For the 1995–96 transfer year, the nonfederal share of the secondary supplemental payment adjustments described in paragraph (9) of subdivision (y) of Section 14105.96 shall be funded as follows:

(i) Ninety-nine percent of the nonfederal share shall be funded by a transfer from the University of California.

(ii) One percent of the nonfederal share shall be funded by transfers from those public entities that are the licensees of the hospitals included in the “other public hospitals” group referred to in clauses (ii) and (iii) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98. The transfer responsibilities for this 1 percent shall be allocated to the particular public entities on a pro rata basis, based on a formula or formulae customarily used by the department for allocating transfer amounts under this section. The formula or formulae shall take into account, through reallocation of transfer amounts as appropriate, the situation of hospitals whose secondary supplemental payment adjustments are restricted due to the application of the limitation set forth in clause (v) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98.



(iii) All transfer amounts under this subparagraph shall be paid by the particular transferor entities within 30 days after the department notifies the transferor entity in writing of the transfer amount to be paid.

(C) For the 1997–98 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustments described in subdivision (af) of Section 14105.98 shall be funded by a transfer from the County of Los Angeles.

(D) (i) For the 1998–99 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustment amounts arising under subdivision (ah) of Section 14105.98 shall be increased as set forth in clause (ii).

(ii) The transfer amounts otherwise calculated to fund the supplemental payment adjustments referred to in clause (i) shall be increased on a pro rata basis by an amount equal to 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d).

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide database file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 443.31 or 128735 of the Health and Safety Code, for hospital fiscal years that ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 439.2 or 127285 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.



(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 443.31 or 128735 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) Transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal state plan.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars (\$15,000,000).

(6) Notwithstanding any other provision of law, except for subparagraph (D) of paragraph (2), the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) or (g) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in subdivision (d).

(7) (A) Except as provided in subparagraphs (B) and (C) and in paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars (\$2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the amounts in the fund, that are not expended, or estimated to be required for expenditure, under Section 14105.98 with respect to a particular transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995, and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities:

(C) With respect to those particular amounts in the fund resulting solely from the provisions of subparagraph (D) of paragraph (2), the department shall determine by September 30, 1999, whether these particular amounts exceed 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred



to in paragraph (2) of subdivision (d). Any excess amount so determined shall be returned to the particular transferor entities on a pro rata basis no later than October 31, 1999.

(D) Regarding any funds returned to a transferor entity under subparagraph (A) or (C), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments.

(2) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. However, for the 1997–98 and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in the form of periodic installments according to a timetable established by the department. The timetable shall be structured to effectuate, on a reasonable basis, the prompt distribution of all nonsupplemental payment adjustments under Section 14105.98, and transfers to the Health Care Deposit Fund under subdivision (d).

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(3) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.



(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with the health care provider, shall be channeled through a transferor entity or any other public entity to the fund, unless the donated funds will qualify under federal rules as a valid component of the nonfederal share of the Medi-Cal program and will be matched by federal funds. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All transfer amounts received by the Controller or amounts offset by the Controller shall immediately be deposited in the fund.

(l) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.



(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164, shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) Except as otherwise permitted by state and federal law, no transfer amount submitted to the Controller under this section, and no offset by the Controller pursuant to subdivision (j), shall be claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars (\$10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated without regard to fiscal years to the State Department of Health Services to be used to support the development of managed care programs under the department’s plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity, and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department’s plan to expand Medi-Cal managed care.



(3) Entities contracting with the department for any portion of the ten million dollars (\$10,000,000) shall meet the objectives of the department's plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars (\$10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the medicaid program.

(q) (1) Any local initiative entity that has performed unanticipated additional work for the purposes identified in subparagraph (B) of paragraph (2) of subdivision (p) resulting in additional costs attributable to the development of its local initiative health delivery system, may file a claim for reimbursement with the department for the additional costs incurred due to delays in start dates through the 1996–97 fiscal year. The claim shall be filed by the local initiative entity not later than 90 days after the effective date of the act adding this subdivision, and shall not seek extra compensation for any sum that is or could have been asserted pursuant to the contract disputes and appeals resolution provisions of the local initiative entity's respective two-plan model contract. All claims for unanticipated additional incurred costs shall be submitted with adequate supporting documentation including, but not limited to, all of the following:

(A) Invoices, receipts, job descriptions, payroll records, work plans, and other materials that identify the unanticipated additional claimed and incurred costs.

(B) Documents reflecting mitigation of costs.

(C) To the extent lost profits are included in the claim, documentation identifying those profits and the manner of calculation.

(D) Documents reflecting the anticipated start date, the actual start date, and reasons for the delay between the dates, if any.

(2) In determining any amount to be paid, the department shall do all of the following:

(A) Conduct a fiscal analysis of the local initiative entity's claimed costs.

(B) Determine the appropriate amount of payment, after taking into consideration the supporting documentation and the results of any audit.

(C) Provide funding for any such payment, as approved by the Department of Finance through the deficiency process.



(D) Complete the determination required in subparagraph (B) within six months after receipt of a local initiative entity's completed claim and supporting documentation. Prior to final determination, there shall be a review and comment period for that local initiative entity.

(E) Make reasonable efforts to obtain federal financial participation. In the event federal financial participation is not allowed for this payment, the state's payment shall be 50 percent of the total amount determined to be payable.

SEC. 89. Section 14495.10 of the Welfare and Institutions Code is amended to read:

14495.10. (a) The department shall establish a pilot program to provide continuous skilled nursing care as a benefit of the Medi-Cal program, when those services are provided in accordance with an approved federal waiver meeting the requirements of subdivision (b). "Continuous skilled nursing care" means medically necessary care provided by, or under the supervision of, a registered nurse within his or her scope of practice, seven days a week, 24 hours per day, in a health facility participating in the pilot program. This care shall include a minimum of eight hours per day provided by or under the direct supervision of a registered nurse. Each health facility providing continuous skilled nursing care in the pilot program shall have a minimum of one registered nurse or one licensed vocational nurse awake and in the facility at all times.

(b) The department shall submit to the federal Health Care Financing Administration, no later than April 1, 2000, a federal waiver request developed in consultation with the State Department of Developmental Services and the Association of Regional Center Agencies, pursuant to Section 1915(b) of the federal Social Security Act to provide continuous skilled nursing care services under the pilot program.

(c) (1) The pilot program shall be conducted to explore more flexible models of health facility licensure to provide continuous skilled nursing care to developmentally disabled individuals in the least restrictive health facility setting, and to evaluate the effect of the pilot program on the health, safety, and quality of life of individuals, and the cost-effectiveness of this care. The evaluation shall include a review of the pilot program by an independent agency.

(2) Participation in the pilot program shall include 10 health facilities provided that the facilities meet all eligibility requirements. The facilities shall be approved by the department, in consultation with the State Department of Developmental Services and the appropriate regional center agencies, and shall meet the requirements of subdivision (e). Priority shall be given to facilities with four to six beds, to the extent those facilities meet all other eligibility requirements.



(d) Under the pilot program established in this section, a developmentally disabled individual is eligible to receive continuous skilled nursing care if all of the following conditions are met:

(1) The developmentally disabled individual meets the criteria as specified in the federal waiver.

(2) The developmentally disabled individual resides in a health facility that meets the provider participation criteria as specified in the federal waiver.

(3) The continuous skilled nursing care services are provided in accordance with the federal waiver.

(4) The continuous skilled nursing care services provided to the developmentally disabled individual do not result in costs that exceed the fiscal limit established in the federal waiver.

(e) A health facility seeking to participate in the pilot program shall provide care for developmentally disabled individuals who require the availability of continuous skilled nursing care, in accordance with the terms of the pilot program. During participation in the pilot program, the health facility shall comply with all the terms and conditions of the federal waiver described in subdivision (b), and shall not be subject to licensure or inspection under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Upon termination of the pilot program and verification of compliance with Section 1265 of the Health and Safety Code, the department shall immediately reinstate the participating health facility's previous license for the balance of time remaining on the license when the health facility began participation in the pilot program.

(f) The department shall implement this pilot program only to the extent it can demonstrate fiscal neutrality, as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals to implement the pilot program and receives federal financial participation from the federal Health Care Financing Administration.

(g) In implementing this article, the department may enter into contracts for the provision of essential administration and other services. Contracts entered into under this section may be on a noncompetitive bid basis and shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(h) This section shall remain in effect only until January 1, 2006, and as of that date is repealed, unless a later enacted statute that becomes effective on or before January 1, 2006, deletes or extends that date.

SEC. 90. Section 16809 of the Welfare and Institutions Code, as amended by Section 45 of Chapter 171 of the Statutes of 2001, is amended to read:



16809. (a) (1) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program. The County Medical Services Program shall have responsibilities for specified health services to county residents certified eligible for those services by the county.

(2) If the County Medical Services Program Governing Board contracts with the department to administer the County Medical Services Program, that contract shall include, but need not be limited to, all of the following:

(A) Provisions for the payment to participating counties for making eligibility determinations based on the formula used by the County Medical Services Program for the 1993–94 fiscal year.

(B) Provisions for payment of expenses of the County Medical Services Program Governing Board.

(C) Provisions relating to the flow of funds from counties' vehicle license fees, sales taxes, and participation fees and the procedures to be followed if a county does not pay those funds to the program.

(D) Those provisions, as applicable, contained in the 1993–94 fiscal year contract with counties under the County Medical Services Program.

(3) The contract between the department and the County Medical Services Program Governing Board shall require that the County Medical Services Program Governing Board shall reimburse three million five hundred thousand dollars (\$3,500,000) for the state costs of providing administrative support to the County Medical Services Program. The department may decline to implement decisions made by the governing board that would require a greater level of administrative support than that for the 1993–94 fiscal year. The department may implement decisions upon compensation by the governing board to cover that increased level of support.

(4) The contract between the department and the County Medical Services Program Governing Board may include provisions for the administration of a pharmacy benefit program and, pursuant to these provisions, the department may negotiate, on behalf of the County Medical Services Program, rebates from manufacturers that agree to participate. The governing board shall reimburse the department for staff costs associated with this paragraph.

(5) The department shall administer the County Medical Services Program pursuant to the provisions of the 1993–94 fiscal year contract with the counties and regulations relating to the administration of the program until the County Medical Services Program Governing Board

executes a contract for the administration of the County Medical Services Program and adopts regulations for that purpose.

(6) The department shall not be liable for any costs related to decisions of the County Medical Services Program Governing Board that are in excess of those set forth in the contract between the department and the County Medical Services Program Governing Board.

(b) Each county intending to participate in the County Medical Services Program pursuant to this section shall submit to the Governing Board of the County Medical Services Program a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year in which the county will participate in the County Medical Services Program.

(c) A county participating in the County Medical Services Program pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) (1) The County Medical Services Program Account is established in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(A) Any interest earned upon money deposited in the account.

(B) Moneys provided by participating counties or appropriated by the Legislature to the account.

(C) Moneys loaned pursuant to subdivision (q).

(2) The methods and procedures used to deposit funds into the account shall be consistent with the methods used by the program during the 1993–94 fiscal year.

(e) Moneys in the program account shall be used by the department, pursuant to its contract with the County Medical Services Program Governing Board, to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j) and to pay for the expense of the governing board as set forth in the contract between the board and the department. In addition, moneys in this account may be used to reimburse the department for state costs pursuant to paragraph (3) of subdivision (a).

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982–83

fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, County Medical Services Program Governing Board expenses, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) A separate County Medical Services Program Reserve Account is established in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final settlement occurring no more than 12 months later. Moneys in this account shall be utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing to participate in the County Medical Services Program under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees as determined by the County Medical Services Program Governing Board pursuant to subdivision (i). Nothing in this section shall preclude the CMSP Governing Board from establishing other reserves.

(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (q) shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay participation fees as established by the County Medical Services Program Governing Board and their jurisdictional risk amount in a method that is consistent with that established in the 1993–94 fiscal year.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the CMSP Governing Board.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.



(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991–92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) (i) Beginning in the 1992–93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, and 2002–03 fiscal years. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus the additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, and 2002–03 fiscal years. In the 1994–95 fiscal year, the amount of the state risk shall be twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, in addition to the cost of administrative support pursuant to paragraph (3) of subdivision (a).

(ii) For the 1999–2000, 2000–01, 2001–02, and 2002–03 fiscal years, the state shall not be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus any additional cost increases for the 1999–2000, 2000–01, 2001–02, and 2002–03 fiscal years.

(C) The CMSP Governing Board, after consultation with the department, shall establish uniform eligibility criteria and benefits for the County Medical Services Program.

(2) For the 1991–92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine	\$ 13,150
Amador	620,264
Butte	5,950,593
Calaveras	913,959
Colusa	799,988

Del Norte	781,358
El Dorado	3,535,288
Glenn	787,933
Humboldt	6,883,182
Imperial	6,394,422
Inyo	1,100,257
Kings	2,832,833
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062
Modoc	469,034
Mono	369,309
Napa	3,062,967
Nevada	1,860,793
Plumas	905,192
San Benito	1,086,011
Shasta	5,361,013
Sierra	135,888
Siskiyou	1,372,034
Solano	6,871,127
Sonoma	13,183,359
Sutter	2,996,118
Tehama	1,912,299
Trinity	611,497
Tuolumne	1,455,320
Yuba	2,395,580

(3) Beginning in the 1991–92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990–91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified by the County Medical Services Program Governing Board as participation fees.

(A)

Jurisdiction	Amount
Lake	\$1,022,963
Mendocino	1,654,999



Merced	2,033,729
Placer	1,338,330
San Luis Obispo	2,000,491
Santa Cruz	3,037,783
Yolo	1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the CMSP Governing Board before a county is permitted to participate in the County Medical Services Program.

(4) For the 1994–95 and 1995–96 fiscal years, the specific amounts and method of apportioning risk to each participating county may be adjusted by the CMSP Governing Board.

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Contracts of the department pursuant to this section shall have no force or effect unless they are approved by the Department of Finance.

(l) The state shall not incur any liability except as specified in this section.

(m) Third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 may be pursued.

(n) Under the program provided for in this section, the department may reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with hospitals, the commission may seek terms which allow reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department may collectively pursue identified options for the realization of program savings.



(q) The Department of Finance may authorize a loan of up to thirty million dollars (\$30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) Regulations adopted by the department pursuant to this section shall remain operative and shall be used to operate the County Medical Services Program until a contract with the County Medical Services Program Governing Board is executed and regulations, as appropriate, are adopted by the County Medical Services Program Governing Board. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, those regulations adopted under the County Medical Services Program shall become inoperative until January 1, 1998, except those regulations that the department, in consultation with the County Medical Services Program Governing Board, determines are needed to continue to administer the County Medical Services Program. The department shall notify the Office of Administrative Law as to those regulations the department will continue to use in the implementation of the County Medical Services Program.

(s) Moneys appropriated from the General Fund to meet the state risk as set forth in subparagraph (B) of paragraph (1) of subdivision (j) shall not be available for those counties electing to disenroll from the County Medical Services Program.

(t) This section shall remain in effect only until January 1, 2008, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2008, deletes or extends that date.

SEC. 91. Section 16809 of the Welfare and Institutions Code, as amended by Section 2 of Chapter 669 of the Statutes of 1997, is amended to read:

16809. (a) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, may enter into a contract with the department and the department may enter into a contract with that county under which the department agrees to administer the program responsibilities for specified health services to county residents certified eligible for those services by the county.

(b) Each county intending to contract with the department pursuant to this section shall submit to the department a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year for which the agreement will be in effect in accordance with procedures established by the department.



(c) A county contracting with the department pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) The department shall establish the County Medical Services Program Account in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(1) Any interest earned upon money deposited in the account.

(2) Moneys provided by participating counties or appropriated by the Legislature to the account.

(3) Moneys loaned pursuant to subdivision (q).

(e) Moneys in the program account shall be used by the department to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j).

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982–83 fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) The department shall establish a separate County Medical Services Program Reserve Account in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final settlement occurring no more than 12 months later. Moneys in this account shall be utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing to contract with the department under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees required by Section 16809.3.



(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (q), shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay by the 15th of each month the agreed-upon contract amount. In the event a county does not make the agreed-upon monthly payment, the department may terminate the county's participation in the program.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the Small County Advisory Committee.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.

(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991–92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) Beginning in the 1992–93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 2002–03 fiscal year. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600 according to the table specified in paragraph (2) to the County Medical Services Program, plus additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year.

(C) As a condition of the state assuming this risk, the department may require uniform eligibility criteria and benefits to be provided which shall be mutually established by participating counties in conjunction with the department. The County Medical Services Program Governing Board may revise these eligibility criteria and benefits or alter rates of payment in order to assure that expenditures do not exceed the funds available in the program account.



(2) For the 1991–92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine	\$ 13,150
Amador	620,264
Butte	5,950,593
Calaveras	913,959
Colusa	799,988
Del Norte	781,358
El Dorado	3,535,288
Glenn	787,933
Humboldt	6,883,182
Imperial	6,394,422
Inyo	1,100,257
Kings	2,832,833
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062
Modoc	469,034
Mono	369,309
Napa	3,062,967
Nevada	1,860,793
Plumas	905,192
San Benito	1,086,011
Shasta	5,361,013
Sierra	135,888
Siskiyou	1,372,034
Solano	6,871,127
Sonoma	13,183,359
Sutter	2,996,118
Tehama	1,912,299
Trinity	611,497
Tuolumne	1,455,320
Yuba	2,395,580

(3) Beginning in the 1991–92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the

1990–91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified in Section 16809.3.

(A)

Jurisdiction	Amount
Lake	1,022,963
Mendocino	1,654,999
Merced	2,033,729
Placer	1,338,330
San Luis Obispo	2,000,491
Santa Cruz	3,037,783
Yolo	1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the department. This amount shall be subject to the approval of both the Department of Finance and the Small County Advisory Committee before a county is permitted to contract back with the department.

(4) For the 1992–93 fiscal year and fiscal years thereafter, the amounts of the jurisdictional risk limitations shall be adjusted according to the provisions of paragraph (2).

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Contracts shall have no force and effect unless approved by the Department of Finance.

(l) The state shall not incur any liability except as specified in this section.

(m) The department may pursue third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3.

(n) Under the program provided for in this section, the department shall reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with hospitals, the commission may seek terms which allow



reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department shall collectively pursue identified options for the realization of program savings.

(q) The Department of Finance may authorize a loan of up to thirty million dollars (\$30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) This section shall become operative January 1, 2008.

SEC. 91.5. Section 16809.4 of the Welfare and Institutions Code is amended to read:

16809.4. (a) Counties voluntarily participating in the County Medical Services Program pursuant to Section 16809 may establish the County Medical Services Program Governing Board pursuant to procedures contained in this section. The board shall govern the CMSP program.

(b) The membership of the board shall be comprised of all of the following:

(1) Three members who shall each be a member of a county board of supervisors.

(2) Three members who shall be county administrative officers.

(3) Two members who shall be county welfare directors.

(4) Two members who shall be county health officials.

(5) One member who shall be the Secretary of the Health and Welfare Agency, or his or her designee, and who shall serve as an ex officio, nonvoting member.

(c) The board may establish its own bylaws and operating procedures.

(d) The voting membership of the board shall meet all of the following requirements:

(1) All of the members shall hold office or employment in counties that participate in the CMSP program.

(2) The initial CMSP Governing Board shall be composed of the incumbent members of the Small County Advisory Committee holding office on the effective date of this section. Those members shall choose one additional county supervisor and one additional county administrative officer. The initial CMSP Governing Board shall hold office until April 1, 1995.



(3) The initial CMSP Governing Board shall be succeeded on April 1, 1995, by a board chosen in the following order so as to ensure that no two representatives shall be from the same county.

Following the effective date of this section:

(A) The three county supervisor members shall be elected by the CMSP counties acting prior to February 1, 1995, with each county having one vote and convened at the call of the Chair of the CMSP Governing Board.

(B) The three county administrative officers shall be elected by the administrative officers of the CMSP counties convened at the call of the Chair of the CMSP Governing Board prior to February 15, 1995.

(C) The two county health officials shall be selected by the health officials of the CMSP counties convened at the call of the Chair of the CMSP Governing Board prior to March 1, 1995.

(D) The two county welfare directors shall be elected by the welfare directors of the CMSP counties convened at the call of the Chair of the CMSP Governing Board prior to March 15, 1995.

(4) Board members shall serve three-year terms.

(5) No two persons from the same county may serve as members of the board at the same time.

(e) (1) The board shall convene its first meeting at the call of the Chair of the Small County Advisory Committee, who shall serve as interim chairperson of the board.

(2) The board may elect a permanent chair.

(f) (1) The CMSP Governing Board is hereby established with the following powers:

(A) Determine program eligibility and benefit levels.

(B) Establish reserves and participation fees.

(C) Establish procedures for the entry into, and disenrollment of counties from the County Medical Services Program. Disenrollment procedures shall be fair and equitable.

(D) Establish cost containment and case management procedures, including, but not limited to, alternative methods for delivery of care and alternative methods and rates for those authorized by the department.

(E) Sue and be sued in the name of the CMSP Governing Board.

(F) Apportion jurisdictional risk to each county.

(G) Utilize procurement policies and procedures of any of the participating counties as selected by the governing board.

(H) Make rules and regulations.

(I) Make and enter into contracts or stipulations of any nature with a public agency or person for the purposes of governing or administering the CMSP.

(J) Purchase supplies, equipment, materials, property, or services.

(K) Appoint and employ staff to assist the CMSP Governing Board.

(L) Establish rules for its proceedings.

(M) Accept gifts, contributions, grants, or loans from any public agency or person for the purposes of this program.

(N) Negotiate and set rates, charges, or fees with service providers, including alternative methods of payment to those used by the department.

(O) Establish methods of payment that are compatible with the administrative requirements of the department's fiscal intermediary during the term of any contract with the department for the administration of the CMSP.

(P) Use generally accepted accounting procedures.

(2) The Legislature finds and declares that the amendment of subparagraph (N) of paragraph (1) in 1995 is declaratory of existing law.

(g) (1) The CMSP Governing Board shall be considered a "public entity" for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and a "local public entity" for purposes of Part 3 (commencing with Section 900) of Division 3.6 of Title 1 of the Government Code, but shall not be considered a "state agency" for purposes of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and shall be exempt from that chapter. No participating county shall have any liability for civil judgments awarded against the County Medical Services Program or the board. Nothing in this paragraph shall be construed to expand the liability of the state with respect to the County Medical Services Program beyond that set forth in Section 16809. Nothing in this paragraph shall be construed to relieve any county of the obligation to provide health care to indigent persons pursuant to Section 17000.

(2) Before initiating any proceeding to challenge rates of payment, charges, or fees set by the board, to seek reimbursement or release of any funds from the County Medical Services Program, or to challenge any other action by the board, any prospective claimant shall first notify the board, in writing, of the nature and basis of the challenge and the amount claimed. The board shall consider the matter within 60 days after receiving the notice and shall promptly thereafter provide written notice of the board's decision. This paragraph shall have no application to provider audit appeals conducted pursuant to Article 1.5 (commencing with Section 51016) of Chapter 3 of Division 3 of Title 22 of the California Code of Regulations and shall apply to all claims not reviewed pursuant to Sections 51003 or 51015 of Title 22 of the California Code of Regulations.

(3) All regulations adopted by the CMSP Governing Board shall clearly specify by reference the statute, court decision, or other provision



of law that the governing board is seeking to implement, interpret, or make specific by adopting, amending, or repealing the regulation.

(4) No regulation adopted by the governing board is valid and effective unless the regulation meets the standards of necessity, authority, clarity, consistency, and nonduplication, as defined in paragraph (4).

(5) The following definitions govern the interpretation of this subdivision:

(A) “Necessity” means the record of the regulatory proceeding that demonstrates by substantial evidence the need for the regulation. For purposes of this standard, evidence includes, but is not limited to, facts, studies, and expert opinion.

(B) “Authority” means the provision of law that permits or obligates the CMSP Governing Board to adopt, amend, or repeal a regulation.

(C) “Clarity” means that the regulation is written or displayed so that the meaning of the regulation can be easily understood by those persons directly affected by it.

(D) “Consistency” means being in harmony with, and not in conflict with, or contradictory to, existing statutes, court decisions, or other provisions of law.

(E) “Nonduplication” means that a regulation does not serve the same purpose as a state or federal statute or another regulation. This standard requires that the governing board identify any state or federal statute or regulation that is overlapped or duplicated by the proposed regulation and justify any overlap or duplication. This standard is not intended to prohibit the governing board from printing relevant portions of enabling legislation in regulations when the duplication is necessary to satisfy the clarity standard in subparagraph (C). This standard is intended to prevent the indiscriminate incorporation of statutory language in a regulation.

(h) The requirements of the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code) shall apply to the meetings of the CMSP Governing Board, except as otherwise provided in this subdivision. The board may meet in closed session to consider and take action on matters pertaining to contracts and contract negotiations with providers of health care services. The governing board shall comply with the following procedures for public meetings held to eliminate or reduce the level of services, restrict eligibility for services, or adopt regulations:

(1) Provide prior public notice of those meetings.

(2) Provide that notice not less than 30 days prior to those meetings.

(3) Publish that notice in a newspaper of general circulation in each participating CMSP county.



(4) Include in the notice, at a minimum, the amount and type of each proposed change, the expected savings, and the number of persons affected.

(5) Hold those meetings in the county seats of at least four regionally distributed CMSP participating counties.

(6) Locate those meetings so as to provide that each hearing will be within a four-hour one-way drive of one quarter of the target population so that the four meetings shall be held at locations in the state that will ensure that each member of the target population may reach at least one of the meetings by a one-way drive that does not exceed four hours.

(i) Records of the County Medical Services Program and of the CMSP Governing Board that relate to rates of payment or to the board's negotiations with providers of health care services or to the board's deliberative processes regarding either shall not be subject to disclosure pursuant to the Public Records Act (Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(j) The following definitions shall govern the construction of this part, unless the context requires otherwise:

(1) "CMSP Governing Board" means the County Medical Services Program Governing Board established pursuant to this section.

(2) "Board" means the County Medical Services Program Governing Board established pursuant to this section.

(3) "CMSP" means the program by which health care services are provided to eligible persons in those counties electing to participate in the CMSP pursuant to Section 16809.

(4) "CMSP county" means a county that has elected to participate pursuant to Section 16809 in the CMSP.

(k) Any references to the "County Medical Services Program" or "CMSP county" in this code shall be defined as set forth in this section.

(l) This section shall remain in effect only until January 1, 2008, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2008, deletes or extends that date.

SEC. 92. Section 18925 of the Welfare and Institutions Code is amended to read:

18925. (a) The State Department of Health Services, in conjunction with the State Department of Social Services, shall implement a simplified eligibility process as part of the Food Stamp Program to expedite Medi-Cal program and Healthy Families Program enrollment for Food Stamp Program recipients, including children and their eligible parents or caretaker relatives who are not enrolled in those programs.

(b) Each county welfare department shall develop a data list of family members residing in eligible food stamp households who are not enrolled in the Medi-Cal program or the Healthy Families Program.

(c) The county welfare department shall develop a notice informing individuals identified pursuant to subdivision (b) that they may be entitled to receive benefits under the Medi-Cal program or the Healthy Families Program.

(d) At the time of the food stamp household's annual recertification, the county welfare department shall send the notice specified in subdivision (c) to the individuals identified in subdivision (b). The notice shall include a request for permission to use the information in the food stamp recipient's case file to make a determination of eligibility for the Medi-Cal program and the Healthy Families Program.

(e) The notice shall be written in culturally and linguistically appropriate language and at an appropriate literacy level. The notice shall include information on the Medi-Cal program and the Healthy Families Program, and a telephone number that food stamp recipients may call for additional information.

(f) To apply for medical assistance under the Medi-Cal program, the food stamp recipient shall sign, date, and return the notice requesting that an eligibility determination be made. Upon receipt of the notice, the county welfare department shall make an eligibility determination by utilizing the information in the food stamp recipient's case file or paper application. The Medi-Cal application date shall be the date the notice is received by the county welfare department. If the food stamp case file does not include sufficient information to establish Medi-Cal program eligibility, the county welfare department shall request, either orally or in writing, additional information from the food stamp recipient.

(g) If the food stamp recipient is determined to be eligible to participate in the Medi-Cal program with a share of cost, or is determined to be ineligible for Medi-Cal, information pertinent to the food stamp recipient's eligibility for the Healthy Families Program shall be forwarded by the county welfare department to the Healthy Families Program statewide administrator for immediate processing. If there is insufficient information to establish Healthy Families Program eligibility, the administrator shall request, either orally or in writing, additional information from the food stamp recipient.

(h) Counties shall include the cost of implementing this section in their annual administrative budget requests to the State Department of Health Services.

(i) This section shall be implemented on or after July 1, 2003, but only to the extent federal financial participation is available.

SEC. 93. The State Department of Health Services may adopt emergency regulations to implement the applicable provisions of this act in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part

1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the first readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

SEC. 94. The department may not recoup any overpayment made to a provider before October 1, 2002, pursuant to Section 14109 of the Welfare and Institutions Code for ambulance transport services, if the overpayment is not due to the fault of the provider.

SEC. 95. (a) The State Department of Health Services shall complete the design and implementation of the Children's Medical Services Network (CMS Net) Enhancement 47 project to ensure that all system enhancements for CMS Net, the California Medicaid Management Information System (CA-MMIS), and the California Dental Management Information System (CD-MMIS) that are required to enable providers in the California Children's Services (CCS) provider network to submit electronic claims for reimbursement for services provided to CCS eligible children are operational by August 1, 2004.

(b) The department shall work in cooperation with county CCS programs that are not yet participating in CMS Net to take all necessary action within available resources to expedite the transition of these county programs to CMS Net for the provision of automated case management and service authorization for all CCS eligible children in their county caseload.

SEC. 96. (a) The California Health and Human Services Agency shall develop a comprehensive plan describing the actions that California may take to improve its long-term care system so that its residents have available an array of community care options that allow them to avoid unnecessary institutionalization. The plan shall respond to the decision of the United States Supreme Court in *Olmstead v. L.C.* (1999) 527 U.S. 581 and shall embody the six principles for an "Olmstead Plan" as articulated by the federal Center for Medicaid and Medicare Services. These principles include:

- (1) A comprehensive, effectively working plan.
- (2) A plan development and implementation process that provides for the involvement of consumers and other stakeholders.



(3) The development of assessment procedures and practices that prevent or correct current and future unjustified institutionalization of persons with disabilities.

(4) An assessment of the current availability of community-integrated services, identification of gaps in service availability, and evaluation of changes that could be made to enable consumers to be served in the most integrated setting possible.

(5) The inclusion in the plan of practices by which consumers are afforded the opportunity to make informed choices among the services available to them.

(6) Elements in the plan that ensure that services are provided in the most integrated setting appropriate and that the quality of services meets the needs of the consumers.

(b) The plan required under subdivision (a) shall be submitted to the Legislature on or before April 1, 2003.

SEC. 97. It is the intent of the Legislature that a significant portion of funds received in the 2003–04 fiscal year and subsequent fiscal years, due to increased federal financial participation attributable to the medicaid home- and community-based waiver program under Section 1396n of Title 42 of the United States Code or other similar initiatives, shall be used to increase the rates for community-based providers serving individuals with developmental disabilities and other actions related to expanding and improving services and supports. The purpose of these fund adjustments shall be to increase community living options, provide expanded consumer choice, provide for increased health and physical safety, and improve the overall stability of community-based services and supports.

SEC. 98. The State Department of Developmental Services shall ensure that funds appropriated in Item 4300-101-0001 of the Budget Act of 2002 to address concerns regarding the potential underfunding of regional center operations shall be used by each regional center toward achieving and maintaining service coordinator caseloads, as contained in subdivision (c) of Section 4640.6 of the Welfare and Institutions Code. In addition, these funds may be used to provide for increased clinical staff as necessary to meet requirements under the federal home- and community-based waiver program (42 U.S.C. Sec. 1396n).

SEC. 99. The State Department of Developmental Services shall ensure that funds appropriated in Item 4300-101-0001 of the Budget Act of 2002 for the purpose of funding a federal program coordinator position at each regional center will be used only for that purpose. This position shall address issues pertaining to federally funded programs serving individuals with developmental disabilities as appropriate, including the home- and community-based waiver program (42 U.S.C.



Sec. 1396n), as well as seeking increased federal financial participation when practicable.

SEC. 100. (a) Of the amount appropriated in Item 4300-101-0001 of the Budget Act of 2002, up to five million six hundred thousand dollars (\$5,600,000) may be used to provide one-time only grant awards to community-based service providers to conduct resource development activities for hard-to-serve populations, including dual diagnosis, and medically and behaviorally challenged individuals who have been identified through the community placement plan process as being appropriate for community placement and whose needs cannot otherwise be met within the existing array of service options in the community.

(b) The grant awards shall be allocated pursuant to subdivision (a) by the State Department of Developmental Services with the intent to improve the quality of local services and to stabilize service systems. Regional centers may serve as the fiscal agent for these one-time grants.

SEC. 101. (a) Of the amount appropriated in Item 4260-111-0001 of the Budget Act of 2002 from the Cigarette and Tobacco Products Surtax Fund, twenty-four million eight hundred three thousand dollars (\$24,803,000) shall be allocated in accordance with subdivision (b) for the 2002–03 fiscal year from the following accounts:

(1) Nine million fifteen thousand dollars (\$9,015,000) from the Hospital Services Account.

(2) Two million three hundred twenty-eight thousand dollars (\$2,328,000) from the Physician Services Account.

(3) Thirteen million four hundred sixty thousand dollars (\$13,460,000) from the Unallocated Account.

(b) The funds specified in subdivision (a) shall be allocated proportionately as follows:

(1) Twenty-two million three hundred twenty-four thousand dollars (\$22,324,000) shall be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP), Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(2) Two million four hundred seventy-nine thousand dollars (\$2,479,000) shall be administered and allocated through the rural health services program, Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(c) Funds allocated by this section from the Physician Services Account and the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for the reimbursement of uncompensated emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred to the



Physician Services Account in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code.

(d) Funds allocated by this section from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for reimbursement of uncompensated emergency services, as defined in Section 16953 of the Welfare and Institutions Code, provided in general acute care hospitals providing basic, comprehensive, or standby emergency services. Reimbursement for emergency services shall be consistent with Section 16952 of the Welfare and Institutions Code.

SEC. 102. Notwithstanding any other provision of law, the unencumbered balances, as of June 30, 2002, of the amounts appropriated in Item 4260-001-0589 of Chapter 50 of the Statutes of 1999, Item 4260-001-0589 of Chapter 52 of the Statutes of 2000, and Item 4260-001-0589 of Chapter 106 of the Statutes of 2001 are hereby reappropriated for the purposes specified in those items, and shall be available for encumbrance and expenditure until July 30, 2005.

SEC. 103. (a) In order to implement changes in the level of funding for Medi-Cal services in the Budget Act of 2002, effective August 1, 2002, the Director of Health Services shall eliminate all provider rate increases that were provided, effective August 1, 2000, for services rendered in the Medi-Cal program, except for the supplemental rate for the California Children's Services Program, home health services, shift nursing, nonemergency medical transportation, and family planning physician services. The director shall take this action pursuant to the rate-setting authority provided under subdivision (a) of Section 14105 of the Welfare and Institutions Code. The director shall also conform the rates for the same services rendered by the same provider types in non-Medi-Cal programs pursuant to Section 14105.18 of the Welfare and Institutions Code to those paid in the Medi-Cal program, absent regulations adopted pursuant to subdivision (c) of Section 14105.18 of the Welfare and Institutions Code. The rates for managed health care plans shall be reduced by the actuarial equivalent amount of the provider rate reductions made by this section at the time of the plan's next rate determination.

(b) For purposes of this section, "provider" means any provider participating in the Medi-Cal program that received a rate increase, effective August 1, 2000, but does not include the following:

(1) A general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(2) A skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code.



(3) An intermediate care facility/developmentally disabled as defined in subdivision (g) of Section 1250 of the Health and Safety Code.

(4) An intermediate care facility/developmentally disabled habilitative as defined in subdivision (e) of Section 1250 of the Health and Safety Code.

(5) An intermediate care facility/developmentally disabled-nursing as defined in subdivision (h) of Section 1250 of the Health and Safety Code.

(6) An adult day health care center as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code.

SEC. 104. It is the intent of the Legislature that, in implementing Section 14105.33 of the Welfare and Institutions Code during the 2002–03 fiscal year, the Director of Health Services shall direct the department to negotiate as aggressively as necessary to achieve savings levels related to pharmaceutical contracting identified in the Budget Act of 2002.

SEC. 105. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars (\$1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

SEC. 106. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make necessary statutory changes to implement the Budget Act of 2002 at the earliest possible time, it is necessary that this act go into immediate effect.

